THE IMPACT OF DSM-III-R AND TRANSITIVE DIAGNOSES ON PERCEPTIONS OF A MAN WITH A PSYCHOLOGICAL PROBLEM

By

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THE IMPACT OF DSM-III-R AND TRANSITIVE DIAGNOSES ON PERCEPTIONS OF A MAN WITH A PSYCHOLOGICAL PROBLEM

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This study investigated the ways in which mental illness diagnostic labels are perceived. It was hypothesized that George Kelly's transitive diagnosis approach to interpersonal problems--wherein the unique situation, background, and personal constructions of clients are emphasized--would result in less negative reactions to clients than a traditional, DSM-III-R diagnosis approach--wherein clients are understood by summarizing their psychological problems in a mental illness diagnostic category. Subjects were 364 undergraduate psychology students. Each subject was presented with a vignette describing a fictional man named Jim Johnson. One group of subjects received a vignette indicating that Jim Johnson had a psychological problem, and this problem was described and assigned one of three

DSM-III-R labels. Another group of subjects received a vignette indicating that Jim Johnson had a psychological problem, but for these subjects the problem was described according to one of three transitive diagnoses, each comparable to one of the DSM-III-R diagnoses. A third group functioned as a control, receiving no information about Jim Johnson having ever had a psychological problem.

Results indicated that subjects responded negatively to Jim Johnson when he was assigned either a DSM-III-R or transitive diagnosis. Subjects desired greater social distance from Jim Johnson when he was assigned any form of diagnosis than when he received no diagnosis. Further, subjects evaluated Jim Johnson's behavior as less socially acceptable and his outward impression as less positive when he was given a psychological diagnosis. Negative reactions to Jim Johnson occurred regardless of type of diagnosis. The results can be interpreted as indicating that merely identifying someone as having a psychological problem is stigmatizing for the person being labeled.

CHAPTER 1
INTRODUCTION

The ways in which psychiatric diagnoses affect perceptions of persons has long been debated. Scheff (1966) proposed the controversial idea that labeling an individual in a particular manner influences both the labeled person's self-perceptions and others peoples' perceptions of the labeled person. In other words, Scheff suggested that labels create a self-fulfilling prophecy, in which labeled persons' behaviors come to conform with the labels assigned to them. While research has not fully backed up all of Scheff's (1966) labeling theory formulations, his ideas have been fruitful for mental health professionals, who have been led to investigate the impact of psychiatric diagnostic labels on perceptions of persons. The current study hopes to add to the expansive research literature in this area. In particular, the current study examines differences in the way people respond to a client labeled with a psychological problem when the client is diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (Third Edition, Revised) (DSM-III-R) versus when the client is diagnosed using George Kelly's transitive diagnosis. In addition, the study compares impressions of a person not diagnosed with any psychological problem to impressions of a person diagnosed

with either DSM-III-R or transitive diagnoses. However, before progressing any further it is necessary to briefly introduce DSM diagnosis and transitive diagnosis, and to differentiate them from one another.

The Success of DSM-III and DSM-III-R

Before DSM-III was published in 1980, psychiatric diagnosis was generally regarded as both unreliable and lacking in validity (Kirk & Kutchins, 1992). Due to many improvements in the way in which diagnoses are made, DSM-III and DSM-III-R have been widely embraced by the mental health community, both in the United States and around the world (APA, 1987). DSM-III has been translated into a variety of languages, including French, German, Italian, Japanese, Norwegian, Portuguese, Spanish, and Greek (APA, 1987). There are numerous reasons for the success of DSM-III and DSM-III-R. Both manuals adopted new and innovative ideas for diagnosing mental disorders, and both have had reputations as highly reliable scientific instruments (APA, 1980, 1987). The elements that have made DSM-III, and later DSM-III-R, so successful are discussed in detail in Chapter 2.

DSM-III and DSM-III-R propose distinct categories of disorder. The American Psychiatric Association states:

> The text of DSM-III-R systematically describes each disorder in terms of current knowledge in the following areas: essential features, associated features, age at onset, course, impairment, complications, predisposing factors, prevalence, sex ratio, familial pattern, and differential diagnosis. (APA, 1987, p. xxv)

By providing such detailed information about each disorder, clinicians are supposed to be able to reliably and effectively diagnose each client with one or more specific disorders. While some people have criticized DSM's categorical approach (Adamson, 1989; Dumont, 1984; Vaillant, 1984), it has been useful in a number of ways. For example, it has made it easy to include DSM categories in successive versions of The International Classification of Diseases (ICD), the medical community's disease manual. It has also allowed clinicians a simple, quick way to convey information about clients. Partly because of its ability to provide diagnostic information so efficiently, categorical diagnoses are useful for insurance purposes. While some objections to the diagnostic approach found in DSM-III and DSM-III-R remain, including challenges to claims that DSM-III and DSM-III-R have enhanced reliability, both manuals have been strikingly successful. In the introduction to DSM-III-R, the authors observe that "the impact of DSM-III has been remarkable. Soon after its publication, it became widely accepted in the United States as the common language of mental health clinicians" (APA, p. xvii).

Personal Construct Theory and Transitive Diagnosis

George Kelly's personal construct theory (PCT) "emphasizes the creative capacity of the living thing to represent the environment" (Kelly, 1991a, p. 6). PCT holds that each person represents the environment through a system

of personal constructs. A personal construct is "a representation of the universe, a representation erected by a living creature and then tested against the reality of that universe" (Kelly, 1991a, p. 9). Because personal constructs are erected by individuals, they can also be torn down or altered by individuals. People can try out new personal constructions of the world if they find current constructions limiting or stagnant, or even simply because they want to see the world from an alternative perspective for a while. The main idea is that there are an infinite number of ways in which the world can be construed, and that people need not cling solely to one construction of the world. In other words, in PCT "the universe is real, but it is not inexorable" unless a person "chooses to construe it that way" (Kelly, 1991a, p. 6). The idea that the world can be viewed in an infinite number of ways is known in PCT as constructive alternativism (Kelly, 1970, 1991a, 1991b).

While constructive alternativism holds that DSM-III-R is one potentially useful construct system for understanding abnormal behavior, Kelly (1991b) wished to encourage alternative ways to think about abnormal behavior. According to constructive alternativism, the DSM-III-R construction of abnormal behavior is one of an infinite number of ways to think about abnormal behavior. Kelly felt that "a psychological theory should be considered ultimately expendable. The psychologist should therefore maintain personal independence of his theory" (Kelly, 1991a, p. 31).

DSM-III-R's approach to abnormal behavior, while often useful in conceptualizing clients, is only one method of construing such behavior. Since people are "always faced with constructive alternatives" they "need not continue indefinitely to be the absolute victim either of . . . past history or . . . present circumstances" (Kelly, 1991a, p. 30). In other words, we need not be enslaved by our own constructions (Kelly, 1991a, 1991b).

Kelly (1969, 1991b) did not care for categorical approaches to psychological diagnosis because he felt that they often failed to help clinicians comprehend the unique, individualized construct systems of their clients. Rather than employing categorical diagnostic labels, Kelly preferred an idiographic approach to understanding psychological problems. By employing various construct elicitation techniques, Kelly felt that clinicians could effectively gain access to each client's construct dimensions, and then could evaluate these dimensions as part of understanding the client's psychological problem. Little research has been done on Kelly's (1991b) original formulation of transitive diagnosis. However, recently Faidley and Leitner (1993) made an attempt to actively employ transitive diagnosis with real life clients. A more detailed discussion of transitive diagnosis, including work by Landfield and Epting (1987) and Faidley and Leitner (1993), will be presented in Chapter 2.

Comparing the Way People React to Psychological Diagnoses

Because transitive diagnosis and DSM-III-R diagnosis are substantially different from one another, it seems logical to hypothesize that each might impact differently on perceptions of persons. Data on the effects of traditional, DSM-style diagnoses on impressions of persons has provided mixed results, at best. However, it does seem that, at least under certain circumstances, traditional diagnostic labels produce negative reactions towards the individual labeled. In the present study, an initial attempt was made to investigate the degree to which the effects of psychiatric labeling can be lessened as a function of the method of diagnosis used. Transitive diagnosis and DSM-III-R diagnosis were compared to each other and to a no-diagnosis control group in order to examine the extent to which each kind of diagnosis impacts on perceptions of persons, and the extent to which transitive diagnosis might produce less negative perceptions of persons.

CHAPTER 2
REVIEW OF THE LITERATURE

The first section of this chapter focuses on DSM-style diagnosis. It presents literature pertaining to the origins and development of DSM-style diagnosis, focusing primarily on the two most recent versions of the manual, DSM-III and DSM-III-R. Attention is paid to the history of the DSM, using DSM-III-R to make diagnoses, and to issues of diagnostic reliability and validity. The second section of this chapter discusses Kelly's (1991a, 1991b) transitive diagnosis. It details Kelly's original outline of transitive diagnosis, as well as the more recent approaches of Landfield and Epting (1987) and Faidley and Leitner (1993). Further, it summarizes PCP literature that explicates the differences between DSM-III-R diagnosis and transitive diagnosis. The third section of the chapter addresses common criticisms of psychiatric diagnosis, with an attempt to relate these criticisms, where applicable, to both DSM-III-R and transitive diagnosis. Finally, the fourth section of this chapter explains the major hypotheses of the present study. The study compares the impact that DSM-III-R and transitive diagnoses have on laypersons' impressions of a man described as experiencing a past psychological problem.

DSM Diagnosis

The history of psychiatric diagnosis can be traced all the way back to 2600 BC, when disorders such as melancholia and hysteria were discussed by the Egyptians and Sumerians (Webb, DiClemente, Johnstone, Sanders, & Perley, 1981). There have been many well known historical figures who have played important roles in the development of psychiatric diagnosis, including Hippocrates, Sydenham, Pinel, and Kraepelin (Webb et al., 1981) Emil Kraepelin is perhaps most often referred to when discussing important influences on present day DSM diagnosis. His early attempt at psychiatric classification during the latter part of the nineteenth century in Heidelberg, Germany, greatly influenced later researchers interested in cataloguing psychological disturbances (Kirk & Kutchins, 1992; Webb et al., 1981). In Kraepelin's system, groups of symptoms were monitored over time in order to identify mental diseases; his system provided thorough descriptions of disorders, with the hope that each disorder's etiology would eventually be discovered (Zigler & Phillips, 1961). Kraepelin's idea of organizing symptoms into descriptive, categorical diagnoses can be clearly seen in the various editions of DSM (Kirk & Kutchins, 1992).

Kraepelin's system was not the only early attempt at psychiatric diagnosis. Numerous efforts have been made in the United States during the past century and a half. Most

of the early American psychiatric nosologies were developed in part due to social demands, such as the requirements of the U.S. census (Kirk & Kutchins, 1992). In fact, the first categorization of mental disorders in the U.S. was performed as part of the 1840 census. Idiocy was the only category, and it included those deemed insane (Kirk & Kutchins, 1992; Webb et al., 1981). By the 1880 census, seven mental disorder categories existed: mania, melancholia, paresis, monomania, dementia, epilepsy, and dipsomania (Kirk & Kutchins, 1992; Webb et al., 1981).

Census officials became interested in a more standardized diagnostic system, and eventually asked the American Medico-Psychological Association to develop such a system (Kirk & Kutchins, 1992). In 1918, the American Medico-Psychological Association published the Statistical Manual for the Use of Institutions for the Insane, a manual which contained 22 distinct diagnostic categories (Kirk & Kutchins, 1992). Ten editions of this manual were used between 1918 and 1942, and in 1935 it was incorporated into the American Medical Association's Standard Classified Nomenclature of Disease (Kirk & Kutchins, 1992; Spitzer & Williams, 1983).

The American Psychiatric Association published the original edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952 (APA, 1987; Eysenck, Wakefield, & Friedman, 1983; Kirk & Kutchins, 1992). It contained 106 categories (Kirk & Kutchins, 1992), and greatly

reflected the psychobiologic view of Adolf Meyer (APA, 1987). Meyer's influence was readily seen in the manual's use of the term "reaction," which reminded readers of Meyer's conceptualization of mental disorders as "reactions of the personality to psychological, social, and biological factors" (APA, 1987, p. xviii).

Sixteen years passed before a revision of DSM-I appeared. DSM-II was significant in a number of respects. First, the term "reaction" was eliminated (APA, 1987). Second, the number of diagnostic categories increased from 106 to 182 (Kirk & Kutchins, 1992). Third, DSM-II marked the first time that DSM was planned in conjunction with the International Classification of Diseases manual, which at that time was in its eighth edition (ICD-8). Both DSM-II and ICD-8 were published in 1968 (APA, 1987). Some clinicians found DSM-II biased towards a psychoanalytic perspective (Kirk & Kutchins, 1992). However, APA (1980, 1987) maintained that--other than inclusion of the term "neurosis"--DSM-II was largely atheoretical.

Work on DSM-III began in 1974, with the appointment of the Task Force on Nomenclature and Statistics (APA, 1987; Eysenck et al., 1983; Kirk & Kutchins, 1992). The Task Force was headed by Robert L. Spitzer, and its goal was to revise DSM-II so that the new version would be consistent with ICD-9, but would also provide more detail about each mental disorder than ICD-9 (APA, 1980, 1987; Kirk & Kutchins, 1992; Webb et al., 1981). DSM-III was different from DSM-II in

numerous ways. First, the term "neurosis" was eliminated. Second, the categories and accompanying five-digit codes for each disorder that were used in ICD-9 were also used in DSM-III; this resulted in almost all DSM-III categories being included in ICD-9 (APA, 1980, 1987). Third, DSM-III marked the first attempt to answer critics who claimed that DSM diagnostic categories lacked reliability; extensive field trials were performed as part of the process of developing DSM-III, in an effort to enhance the diagnostic reliability of its categories (APA, 1980, 1987; Eysenck et al., 1983; Kirk & Kutchins, 1992; Spitzer, Endicott, & Robins, 1975; Spitzer, 1984a, 1984b). Fourth, DSM-III introduced the multiaxial approach to diagnosis, wherein diagnoses are made along five specific axes. Perhaps most importantly, the introduction of DSM-III marked a crucial turning point in the manual's history. Unlike its predecessors, DSM-III was widely embraced by the mental health community (APA, 1987; Kirk & Kutchins, 1992), and was praised as a major step in improving the diagnosis of mental disorders.

DSM-III-R was published in 1987 (APA, 1987; Kirk & Kutchins, 1992). The APA's (1987) introduction to DSM-III-R cites the emergence of new reliability data and the need to refine diagnostic criteria as the primary reasons for revising DSM-III. The introductory section of DSM-III-R emphasized that each revision of DSM is only one "still frame" in the scientific process of understanding mental disorders, and that DSM-III-R was simply the latest still

frame. Major changes in DSM-III-R involved revising diagnostic criteria, adding new disorders, and eliminating a few old disorders. Childhood and adolescent disorders, in particular, were substantially revised for DSM-III-R (McConville & Steichen-Asch, 1990). Despite its many changes, DSM-III-R maintained most of the innovations first used in DSM-III. As with DSM-III, diagnostic criteria, multiaxial diagnosis, and use of five-digit codes consistent with ICD-9 were all part of DSM-III-R. Despite DSM-III-R's conceptual similarities to DSM-III, Zimmerman (1990) felt that the revisions made in DSM-III-R were so substantial that it should have been called DSM-IV.

At the time of this writing, DSM-IV (APA, 1994) has been recently published. This fifth version of the DSM was originally planned to come into use in 1993 (Kendell, 1991; Widiger, Frances, Pincus, Davis, & First, 1991), but was eventually set for publication in May, 1994 (Laurence, 1994; Roan, 1994). DSM-IV and ICD-10 were expected to be more similar to each other than were DSM-III and ICD-9 (Kendell, 1991). While some researchers have criticized DSM-IV, questioning the necessity for a revision of DSM-III-R so soon after its publication (Zimmerman, 1988, 1990), others see DSM-IV as an important step in the ever evolving science of psychiatric diagnosis (Kendell, 1991; Widiger et al., 1991). The present study was conducted prior to DSM-IV's publication. However, the DSM-III-R descriptions used in the present study remain similar to those found in DSM-IV.

Components of a DSM-III-R Diagnosis

DSM-III marked a major overhaul of DSM-style diagnosis. It emphasized a descriptive approach to cataloging mental disorders, introduced diagnostic criteria and multiaxial diagnosis, and took great strides in addressing the issue of diagnostic reliability. As mentioned above, most of the changes introduced in DSM-III were also found in its 1987 revision, DSM-III-R. Below, the primary elements important in making a DSM-III-R diagnosis are briefly discussed.

Definition of mental disorder. DSM-III-R cautions that while it "provides a classification of mental disorders, no definition adequately specifies precise boundaries for the concept 'mental disorder'" (APA, 1987, p. xxii). Nevertheless, DSM-III-R defines a mental disorder as being "a clinically significant behavioral or psychological syndrome or pattern that occurs in a person" (APA, 1987, p. xxii). This syndrome or pattern must be considered "a manifestation of a behavioral, psychological, or biological dysfunction in the person" (APA, 1987, p. xxii). While proposing a categorical system for cataloging mental disorders, DSM-III-R does not claim that mental disorders have distinct boundaries; the degree to which various disorders qualitatively differ from each other continues to be researched and debated (APA, 1980, 1987). At the same time, DSM-III-R emphasizes that the diagnoses it contains do not

classify people, but "disorders that people have" (APA, 1987, p.xxiii).

Descriptive approach. DSM-III-R's stated goal is to present atheoretical descriptions of mental disorders; this is because the etiology behind most mental disorders is unknown (APA, 1980, 1987). Further, the authors of DSM-III-R felt that the inclusion of theoretical explanations for each mental disorder would result in conflict between clinicians of different theoretical orientations. As a result, DSM-III-R only offers descriptions of disorders; it does not try to explain the causes of the disorders.

Diagnostic criteria. Prior to DSM-III, diagnostic criteria were not employed in diagnosing mental disorders (Adamson, 1989; APA, 1980, 1987). However, in an effort to enhance reliability, diagnostic criteria were introduced in DSM-III. The diagnostic criteria for a disorder consists of a list of various behaviors that together constitute that disorder; as in DSM-III before it, the description of each DSM-III-R disorder is accompanied by diagnostic criteria. In making diagnoses, clinicians determine whether their clients' behaviors coincide with the required number of behaviors listed in the diagnostic criteria. Clients whose behaviors meet the criteria are diagnosed with the disorder at hand.

Interest in developing diagnostic criteria for the purpose of enhanced reliability can be traced back to the early 1970s. One of the first attempts to develop such criteria reached fruition in 1972, with the "Feighner

criteria" (Adamson, 1989; Kirk & Kutchins, 1992); the "Feighner criteria" greatly influenced the criteria eventually used in DSM-III and DSM-III-R (Adamson, 1989; Kirk & Kutchins, 1992). Diagnostic criteria allowed for more general agreement about the behaviors constituting each disorder. However, while helpful for reliability purposes, the authors of DSM-III-R warn that "it should be understood . . . that for most of the categories the diagnostic criteria are based on clinical judgment, and have not been fully validated" (APA, 1987, p. xxiv). Thus, while diagnostic criteria have enhanced reliability, validity issues remain. More on reliability and validity shortly.

Multiaxial evaluation. Williams (1985a) presents a fascinating and thoroughly detailed history of multiaxial approaches to psychiatric diagnosis. In 1952, the Danish Psychiatric Association adopted a biaxial diagnostic system, a forerunner of the DSM-III multiaxial system (Williams, 1985a). Proposals for a multiaxial approach in DSM began to be discussed in the 1960s, and by the time a first draft of DSM-III was circulated in 1976, a multiaxial system was being developed for the manual (Williams, 1985a).

DSM-III-R describes its multiaxial system as one in which "every case is assessed on several 'axes,' each of which refers to a different class of information" (APA, 1987, p. 15). Axes I and II are the axes used to classify all major mental disorders. The disorders categorized along Axis II constitute personality and developmental disorders, which

are believed to begin in childhood or adolescence, and which are often overlooked "when attention is directed to the usually more florid Axis I disorder" (APA, 1987, p. 16). All disorders not categorized as personality or developmental disorders are listed on Axis I. The distinction between Axis I and Axis II allows clinicians to make simultaneous diagnoses along both axes, or along one or the other axis as is necessary. However, DSM-III-R also points out that it is often appropriate to diagnose clients with more than one disorder along either Axis I or Axis II. For example, both DSM-III and DSM-III-R (APA, 1980, 1987) emphasize that a client may have multiple Axis I disorders (e.g. a psychoactive substance abuse disorder and a mood disorder), as well as multiple Axis II disorders (e.g. a specific developmental disorder and a personality disorder), and both manuals instruct clinicians to diagnose all disorders for which a client meets the necessary criteria. Further, when no Axis II disorder is diagnosed, that axis can be used to list specific personality traits. When multiple diagnoses are made, clinicians are supposed to indicate which is the "principal diagnosis"--that is, the disorder which was principally responsible for the client's entering treatment.

Axis III is not actually used for diagnosing mental disorders. Rather, it is used by clinicians to indicate other physical illnesses afflicting a client that are not mental disorders. Axis III is used to supplement diagnoses made along Axes I and II, and to provide information about

other physical ailments that may be relevant to a client's case (APA, 1987).

Axis IV of DSM-III was heavily criticized (Skodol, 1991; Williams, 1985a). As a result, it was revised for DSM-III-R. In DSM-III-R, Axis IV constitutes the Severity of Psychosocial Stress Scale. Evaluations of psychosocial stress are made along a six point scale, with "1" being "no stress" and "6" being "catastrophic stress." Next to each point on the scale are listed several examples of what constitutes that particular level of stress. Two versions of the scale are provided, one for adults and one for children and adolescents. For example, a Severity of Psychosocial Stress score of "3" is considered to constitute "moderate" stress. For an adult, the following events are considered instances that cause moderate stress: "marriage, marital separation, loss of job, retirement, miscarriage" (APA, 1987, p. 11). For a child, these events are considered instances that cause moderate stress: "expelled from school, birth of a sibling" (APA, 1987, p. 11). Clinicians are instructed to make evaluations of psychosocial stress "based on the clinican's assessment of the stress an 'average' person in similar circumstances and with similar sociocultural values would experience from the particular psychosocial stressor(s)" (APA, 1987, p. 19).

Axis V also changed substantially between DSM-III and DSM-III-R. In DSM-III-R, Axis V is the Global Assessment of Functioning Scale. This scale ranges from 0 to 90. Lower

numbers indicate less ability to function effectively in one's environment. For example, a score of "30" indicates that "behavior is considerably influenced by delusions or hallucinations" (APA, 1987, p. 12). By comparison, a score of "60" indicates only "moderate symptoms" (p.12), while a score of "90" indicates "absent or minimal symptoms" (p.12). A score of "0" indicates not enough information to make a judgment. Two assessments along Axis V are made. The first describes current level of functioning at the time of a client's diagnostic evaluation; the second indicates the clinician's judgment regarding a client's highest level of functioning within the past year.

Reliability and Validity

Research and debate addressing reliability and validity in psychiatric diagnosis are not new. Zigler and Phillips (1961), in their well known article critiquing psychiatric diagnosis, discussed reliability and validity at length and cited studies which found both high and low diagnostic reliability levels. The publication of DSM-III in 1980 marked a turning point in the debate over diagnostic reliability. Part of the reason that DSM-III and DSM-III-R have been more successful than previous editions of the DSM is because of the purported enhanced reliability of the diagnostic categories they contain. DSM-III and DSM-III-R have generally been considered highly reliable diagnostic instruments (APA, 1980, 1987). Below, research on the

reliability and validity of DSM-III and its successor, DSM-III-R, is reviewed.

Reliability and validity defined. In the most general sense, validity is defined as the best approximation of the truth or falsity of a proposition (Cook & Campbell, 1979). While perfect validity is impossible--we can never distinguish with complete certainty true from false--we can know what has not yet been ruled out as false (Cook & Campbell, 1979). A specific kind of validity relevant to diagnosis is construct validity. Construct validity involves the degree to which a theoretical construct measures what it purports to measure (Cook & Campbell, 1979; Smith & Glass, 1987). It is crucial that diagnostic constructs--the many categories employed when classifying abnormal behaviors--measure what they claim to if they are to be useful for clinicians; a clinician employing a diagnostic system unable to differentiate between normality and disorder benefits very little from using that system.

Important in achieving a high level of validity is reliability. Reliability constitutes the degree to which a measure is stable and consistent (Cook & Campbell, 1979). A reliable measure provides similar results each time it is taken. In categorical diagnosis, this is important. If one's measures change each time they are taken, then knowing what category of disorder a client belongs in will be difficult. In a highly reliable system, clinicians reach the same diagnosis each time they assess a client. Further, a

reliable system allows clinicians to reach the same diagnosis of a client independently of one another. Most importantly, a valid system cannot be achieved without a high degree of reliability. Though a reliable system does not guarantee a valid system, a valid system must be reliable (Cook & Campbell, 1979; Smith & Glass, 1987). Because more attention has been paid in the literature to diagnostic reliability than diagnostic validity, most of the research presented below addresses the former.

DSM-III field trials. Appendix F of DSM-III contains the results of field studies performed in order to evaluate the reliability of diagnostic categories found in DSM-III (APA, 1980). Two phases of reliability testing were undertaken as part of these field trials. Phase One used criteria from a January, 1978 draft of DSM-III; Phase Two used revised criteria (APA, 1980). DSM-III provides kappa statistics indicating the degree of reliability for the major classifications of mental disorders. The kappa statistic measures improvements in clinician diagnostic agreement beyond mere random chance (APA, 1980; Kirk & Kutchins, 1992; Spitzer & Fliess, 1974), and is cited in DSM-III as indicating improved reliability over past diagnostic classification systems. Herein, the field trials of DSM-III are discussed because there is no section of DSM-III-R that reports the results of reliability field studies; research on DSM-III-R's reliability was not mentioned at the time of its

publication or included in the manual (Kirk & Kutchins, 1992).

DSM-III indicates that a kappa statistic of 0.7 or higher indicates a high degree of reliability (APA, 1980). The authors of DSM-III claim that, based on kappa statistics, DSM-III has improved reliability over its predecessors. In fact, a good number of diagnostic classes produced kappa statistics that were at or above the 0.7 level. However, DSM-III does make clear that "a high kappa. . . indicates good agreement as to whether or not the patient has a disorder within that diagnostic class, even if there is disagreement about the specific disorder within the class" (APA, 1980, p. 468). In other words, clinicians need only agree about the general class of disorder a client has, not the specific disorder itself. As explained in DSM-III:

> . . . diagnoses of Schizophrenia, Paranoid Type and Schizophrenia, Catatonic Type by two clinicians would be considered agreement on Schizophrenia. Similarly, if one clinician diagnoses Borderline Personality Disorder and the other Schizotypal Personality Disorder, this is considered agreement on whether or not there is a Personality Disorder. (APA, 1980, p. 468)

Thus, the DSM-III field trials assessed diagnostic reliability according to class of disorder, not according to specific disorder type. In order to be considered in diagnostic agreement with each other, clinicians merely had to concur about the class of disorder a client had, not about the specific disorder within that class.

The authors of DSM-III conclude that the field trials point towards enhanced diagnostic reliability for DSM-III

categories. As indicative of the progress made in enhancing reliability during the course of the field trials, the authors of DSM-III point to the fact that Phase Two reliability was, in general, higher than Phase One reliability. Nevertheless, the authors acknowledge several areas in which diagnostic reliability could be enhanced. For example, they express disappointment that the reliability kappas for childhood and adolescent disorders were lower in Phase Two than in Phase One--particularly so for the adjustment disorder category (APA, 1980). Further, they plainly acknowledge that diagnostic reliability for specific personality disorders is not very good, with kappas ranging from 0.26 to 0.75 (APA, 1980). In spite of these disappointments, they conclude that

> several innovative features of DSM-III have undoubtedly contributed to the generally improved diagnostic reliability: changes in the classification itself (e.g. grouping all the Affective Disorders together), the separation of Axis I and Axis II, the systematic description of the various disorders and, finally, the inclusion of diagnostic criteria. (APA, 1980, p. 469)

Some aspects of DSM-III and DSM-III-R reliability have not been closely examined. Williams (1985b) was unable to locate any reliability studies evaluating DSM-III's Axis III, and no Axis III reliability studies were found during the writing of this literature review. Nevertheless, a significant number of studies on DSM-III and DSM-III-R reliability have been conducted, many pertaining to specific disorders. For example, numerous researchers have concerned themselves with the reliability of diagnostic criteria for various affective

disorders (Carroll, 1984; Fogel, 1990; Mazure, Nelson, & Price, 1986). While space prevents an exhaustive review of reliability data for every disorder within DSM-III and DSM-III-R, several important issues regarding the reliability of DSM-III and DSM-III-R are briefly discussed below.

Axis IV. Skodol (1991) reviewed the literature pertaining to Axis IV's reliability. Axis IV, which measures the degree of psychosocial stress a patient is experiencing, was severely criticized when DSM-III was first published. As a result, DSM-III-R altered Axis IV by providing separate examples to help clinicians differentially evaluate clients experiencing acute events and clients experiencing enduring events (Skodol, 1991). Little research into Axis IV's reliability has been done; of these few studies, the DSM-III field trials produced the best reliability results; these results indicated a moderate degree of reliability. Even so, Skodol (1991) notes that nearly half of the clinicians participating in the DSM-III field trial recommended making major changes in Axis IV. As a result of problems with Axis IV, a number of changes were considered for DSM-IV, including possibly eliminating Axis IV altogether in favor of a list of psychological problems (Skodol, 1991).

Axis V. Axis V changed substantially between DSM-III and DSM-III-R. Perhaps this is because research on DSM-III's Axis V yielded mixed to poor reliability levels. For example, Fernando, Mellsop, Nelson, Peace, & Wilson (1986) conducted a study that investigated Axis V's reliability in

DSM-III. In DSM-III, Axis V measured the highest level of adaptive functioning during the past year, and ratings were made along a six point scale. The results of Fernando et al. (1986) produced an intraclass correlation coefficient of only .49, which was substantially lower than the correlation found during the DSM-III field trials. By the time DSM-III-R was published Axis V had been changed entirely, with the new Axis V constituting the Global Assessment of Functioning Scale (discussed earlier). No reliability information for the revised version of Axis V is provided in DSM-III-R.

Reliability and categorical diagnosis. Adamson (1989) contends that while diagnostic criteria served as an improvement, DSM-III and DSM-III-R continue to exhibit poor reliability and validity. He believes that limitations in current knowledge prevent the development of a fully adequate diagnostic system, but also implies that the categorical approach used in the DSMs may be interfering with the ability of researchers to improve reliability and validity. Adamson (1989) argues that a more dimensional approach towards measuring mental disorders might succeed better than the present, categorical approach, but he doubts that DSM-IV will move towards greater use of dimensional measurement. However, Adamson (1989) feels that, despite its problems, each revision of DSM marks an important step forward.

Dumont (1984) also criticizes the categorical approach, but is far less confident than Adamson (1989) about the ability to improve DSM diagnosis. Dumont (1984) believes

that DSM-III marked only a minimal improvement in reliability, much of which was "inflated by the use of 'characteristic' case histories which do not manifest the much more characteristic ambiguities of real-life situations" (p. 327). He argues that categorical diagnosis is bound to be unreliable because it is assumes that "reality comes packaged in well-bounded categories waiting to be discovered" (Dumont, 1984, p. 333). While Adamson (1989) and Dumont (1984) provide very different outlooks for the future improvement of DSM diagnosis, they both present important concerns regarding the difficulties involved in producing a categorical diagnostic system with high levels of reliability.

Selling of DSM. In a recent book, Kirk and Kutchins (1992) argue that the sense of greatly enhanced diagnostic reliability that accompanied DSM-III, and later DSM-III-R, did not occur because either of these manuals was demonstrably more reliable than previous editions of DSM. Rather, they contend that the sense of enhanced reliability resulted from brilliant political maneuverings on behalf of a small group of neo-Kraepelinian researchers intent on seeing the medical model replace the psychodynamic influence present in DSM-II. These researchers, led by DSM-III and DSM-III-R Task Force chair Robert Spitzer, were instrumental in the development of both DSM-III and DSM-III-R. According to Kirk & Kutchins (1992), one way that Spitzer and his colleagues advanced their argument that DSM-III was very reliable was by

introducing the kappa statistic into diagnostic reliability studies.

Kirk and Kutchins (1992) describe how use of the kappa statistic contributed to the perception of DSM-III as reliable, even though they feel that kappa measures themselves did not support such a claim. First, while controversial, the kappa statistic was not understood by most practitioners. This left reliability issues in the hands of researchers and statisticians. As a result, most practitioners were left out of the reliability debate (Kirk & Kutchins, 1992). Second, the kappa statistic transformed reliability from a conceptual problem, threatening the very core of psychiatry and psychiatric diagnosis, "into a technical problem to be solved by research specialists" (Kirk & Kutchins, 1992, p. 44). Transforming reliability into a technical problem gave Spitzer and his colleagues a great deal of power when it came to interpreting the results of reliability studies used in developing DSM-III (Kirk & Kutchins, 1992).

Finally--and perhaps most importantly--since no standards for interpreting the kappa statistic were ever established, issues of diagnostic reliability were subject to widely disparate interpretations, depending on the particular author's goals. Kirk and Kutchins (1992) argue that the researchers involved in the development of DSM-III interpreted kappa statistics in ways that supported their view of DSM-III as substantially more reliable than DSM-II,

interpretations that Kirk and Kutchins (1992) dispute. Kirk and Kutchins (1992) contend that the DSM-III field trial kappa scores purported to indicate enhanced reliability for DSM-III categories were not that different from those Spitzer & Fliess (1974) previously reported as indicating only satisfactory reliability in DSM-II. In other words, Kirk and Kutchins' (1992) central argument is that the DSM-III Task Force interpreted kappa scores in a way which was favorable for DSM-III; despite the acceptance of DSM-III and DSM-III-R as reliable, Kirk and Kutchins (1992) still see reliability as a problem in DSM-III, as well as in DSM-III-R. They claim that the degree to which the DSM's diagnostic reliability was taken for granted by both supporters and critics after DSM-III is dramatically represented by the fact that DSM-III-R, a substantial revision of DSM-III, was accepted as reliable even though no field trials on interrater agreement were ever conducted (Kirk & Kutchins, 1992).

Eysenck's critique. Eysenck et al. (1983) presented one of the more thorough assessments of DSM-III's reliability and validity. Like Adamson (1989), Eysenck et al. (1983) feel that a dimensional approach is preferable to a categorical one. They criticize DSM-III for being highly unreliable, but contend that all forms of diagnosis, even those in more traditional areas of medicine, have low levels of reliability. Eysenck et al. (1983) argue that DSM-III's biggest problem is not reliability, but validity. They question focusing primarily on reliability because "it is the

absence of any indication of validity which is far more critical, as is the absence of any appreciation of the importance of scientific proof for schemes of this kind" (Eysenck et al., 1983, p. 189). Eysenck et al. (1983) feel that psychiatry's aspirations have expanded beyond its scientific abilities. As a result, both validity and reliability have suffered. Eysenck et al. (1983) go so far as to state that "DSM-III is primarily a professional manual and only secondarily, if at all, a scientific manual" (p. 184). In their view, DSM-III is neither reliable nor valid.

Reliable but not valid. Wakefield (1992b) further develops the idea that DSM-III and DSM-III-R suffer from validity problems. He argues that DSM-III-R's definition of mental disorders does not effectively distinguish disorders from non-disorders. For example, Wakefield (1992b) contends that DSM-III-R holds that "a mental disorder is a mental condition that (a) causes distress or disability and (b) is not a statistically expectable response to external events" (p. 238). According to Wakefield (1992b), this definition is simultaneously too broad and too narrow. He observes that it is too broad when considering DSM-III-R's V codes. The V codes, which DSM-III-R indicates are conditions not attributable to mental disorder but which are treated by clinicians, fit the definition of mental disorder but are not considered disorders; using this example, Wakefield observes that the definition of mental disorder is often too inclusive, applying to behaviors most clinicians do not

perceive to be disorders. Likewise, Wakefield (1992b) points out that many behaviors classified as disorders are expectable (e.g. post traumatic stress disorder, anaclitic depression), even though DSM-III-R's definition implies that disordered behavior is statistically unexpectable. While Wakefield (1992b) believes that post traumatic stress disorder constitutes dysfunctional behavior and is therefore legitimately classified as a disorder, he contends that DSM-III-R's definition of mental disorder implies that post traumatic stress is not a disorder because it involves behavior that, following a traumatic incident, can often be expected. In this case, Wakefield (1992b) sees DSM-III-R's definition of mental disorder as too narrow.

Wakefield (1992b) believes that the reason that DSM-III-R's definition of mental disorder lacks validity is because so much attention has been focused on diagnostic reliability. He asserts that enhanced reliability can actually decrease validity because "one need only operationalize criteria in ways that do not correspond to what one is trying to measure" (Wakefield, 1992, p. 241). Wakefield (1992b) feels that DSM-III-R sacrifices validity through its strategy for enhancing reliability. This strategy "attempts to increase reliability by eliminating the inference to internal mechanism failure and relying for diagnostic judgments on the unexpectable nature of the harms alone" (p. 242). Wakefield (1992a, 1992b) defines a dysfunction as the failure of an internal mechanism to function as it is supposed to. He

differentiates the term "dysfunction" from the term "harmful," noting that the former is the failure of an internal mechanism to operate appropriately and the latter is derived from social norms (Wakefield, 1992a). He proposes that in order to improve diagnostic validity, DSM-III-R criteria need to be altered so that they better isolate disorders within the person, rather than unexpectable behaviors that are "due to environmental stresses, lack of education, or other specific nondysfunctional causes" (Wakefield, 1992b, p. 243). Wakefield (1992a, 1992b) believes that DSM-III-R can improve its validity if its authors emphasize internal mechanism dysfunctions.

Validity and cynicism. Brown (1987) conducted a study that looked at the ways in which DSM-III was used in a community mental health center. Often, staff felt the diagnoses assigned to clients were insufficient in describing client problems, and therefore not particularly valid as diagnostic constructs. For example, when assessing one particular client, a resident and his supervisors found the diagnoses available inadequate. They saw the client's behavior "as the central concern, and diagnosis was exactly what the resident believed it to be: the necessity of 'putting some DSM thing on paper'" (Brown, 1987, p. 39).

Labels were used more for bureaucratic reasons than anything else. In fact, clinicians generally regarded DSM-III labels "as imprecise and/or not very helpful" (Brown, 1987, p. 40). Brown (1987) concludes that DSM-III's claims

of validity are exaggerated, given the limitations it puts on clinicians and the negative attitudes many clinicians have towards it. He states that "the inaccuracy of diagnosis, in its restricted DSM-III sense. . . calls into question the validity of diagnosis, therefore producing and heightening diagnostic uncertainty, ambivalence, and conflict" (Brown, 1987, p. 49). Of course, whether or not Brown's findings are due to cynicism on the part of community mental health workers or genuine problems with DSM-III as a diagnostic tool cannot be easily determined from this particular study.

Transitive Diagnosis

Kelly (1991b) outlined a new approach for understanding client problems. This approach, which he called transitive diagnosis, emphasizes understanding the construct systems used by clients in order to best comprehend their presenting problems. Kelly tried to differentiate transitive diagnosis from more traditional, Kraepelinian styles of diagnosis. For example, he made clear that transitive diagnosis emphasizes the process of client change, rather than static categories; one of Kelly's biggest criticisms of traditional diagnostic approaches is their emphasis on static labels. In transitive diagnosis, assessment is continuous, because the client's construct system is always evolving. For Kelly, categorical diagnosis has a hard time emphasizing process because it results in a specific diagnosis which then is maintained

throughout treatment. Kelly's transitive diagnosis involves a continual reevaluation of client constructs. Below, transitive diagnosis is described as Kelly presented it. Then, Bannister's constructivist critique of traditional diagnosis is briefly outlined. Finally, Faidley and Leitner's (1993) more recent elaboration of transitive diagnosis is discussed.

Kelly on Transitive Diagnosis

Kelly (1991b) described transitive diagnosis as "concerned with transitions in the client's life" (p. 153). He felt that traditional approaches to diagnosis "impose preemptive constructions on human behavior. Diagnosis is all too frequently an attempt to cram a whole live struggling client into a nosological category" (p. 154). Kelly (1991b) emphasized that people are always in the process of changing and reconstruing events, and strongly objected to "nosological diagnosis and all the forms of thinking which distract our attention from the fact that life does go on and on" (p. 154). Transitive diagnosis is Kelly's alternative approach to understanding clients and their concerns. Unlike DSM-III-R diagnosis--which usually is completed early in therapy and used to determine treatment--transitive diagnosis is a process which continues throughout therapy. Leitner (in press) describes assessment in transitive diagnosis as involving "psychological description of the client's

constructs, psychological evaluation of the client's construct system, and an analysis of the milieu in which adjustment is sought." Below, all of the elements that Kelly felt were important in making a transitive diagnosis are summarized. Transitive diagnosis is so different from traditional notions of psychiatric diagnosis that Raskin and Epting (1994) suggest that the term "transitive understanding" (rather than transitive diagnosis) might better describe what it entails.

Formulating client problems. The first step in transitive diagnosis involves identifying the client's major problem areas. Leitner (in press) is quick to point out that this does not involve assigning the client to a particular diagnostic category. Rather, it involves understanding a client's constructions of events in order to understand where these constructions are causing the client difficulties. Kelly (1991b) pointed out that clinicians need to consider their own norms when trying to understand client problems. Recent research by Soldz (1989) further illustrates the need for therapists to be aware of their own constructions when evaluating clients. Soldz's (1989) dissertation results indicate that therapists employ different constructs when describing clients than they do when describing acquaintances; in describing clients, constructs relating to emotional stability are employed more often.

In addition to awareness of one's own constructs, awareness of a client's cultural context, personal-social

context, job patterns, and family situation are all important in understanding his or her presenting problem (Kelly, 1991b). Finally, considering the gains and losses that the client experiences as a result of his or her presenting problem is quite important (Kelly, 1991b). At this stage of diagnosis, evaluation of the losses and gains that client behavior produces ought to be tentative. Kelly (1991b) observed that

> . . . in transitive diagnosis the clinician seeks a preliminary overview of these gains and losses in relation to the client's symptoms. He follows this up in a later stage with a more intimate appraisal of these gains and losses in the light of the client's personal constructs. (Kelly, 1991b, p. 168-169)

Describing client constructs. This stage of the diagnostic process has three main components. The first involves understanding clients' own constructions of their problems. While Kelly (1991b) observed that a client's construction of the problem may not always be the most rewarding construction available, it is very important for the clinician to respect and understand the client's construction. The second task of this stage involves learning what clients feel others think the problem is. Finally, clinicians need to evaluate what clients construe their own life roles to be. Kelly (1991b) notes that "the clinician should keep in mind that his client is bound only by the consistent interpretations he places upon his experience" (p. 170). Realizing that client roles are played out in relation to expectations of others can be useful in coming better to understand clients and their problems.

Evaluating the construct system. In evaluating client construct systems, transitive diagnosis focuses on aggression, anxiety, and constriction (Kelly, 1991b). Aggression occurs when people actively test their constructs in an attempt to confirm them; often, clients experience hostility, wherein they try to force events to fit with their constructs rather than acknowledging that their constructs do a poor job accounting for events (Kelly, 1991b). In transitive diagnosis, awareness of areas of hostility and aggression can help clinicians identify areas of the construct system requiring reevaluation (Kelly, 1991b). Anxiety results when one's construct system does not accommodate events; if the clinicians can identify areas of anxiety, they can help clients focus on developing ways to elaborate their systems so as to reduce anxiety (Kelly, 1991b). Finally, constriction involves limiting one's perceptual field in order to avoid impending disconfirmation of one's constructs (Kelly, 1991b). Awareness of ways in which clients constrict their awareness in order protect particular constructions can be quite critical in helping clients during therapy.

Treatment. DSM-III-R diagnosis involves evaluating clients and determining what disorders they suffer from; treatment then proceeds based on the category of disorder a client has. As alluded to earlier, transitive diagnosis takes a somewhat different approach. Kelly (1991b) considered transitive diagnosis to be an ongoing process; the

therapist should always be evaluating and reevaluating client constructions. This is important in the treatment phase of therapy. Kelly felt that clinicians need to approach each client individually. Treatment plans should be created with the particular client in mind. By understanding client constructions, developing an individualized treatment plan is made easier. As new material is uncovered, clinicians are expected to revise and reevaluate their own constructions of the client. Further, as the client changes, clinicians need to reassess client constructs. Because Kelly felt that the therapy process involves helping clients reconstrue events, therapists need to constantly attend to changes within a client's construct system. In is in this regard that transitive diagnosis does not stop after the initial assessment phase of therapy; it continues throughout the course of counseling.

Eliciting constructs. An important part of transitive diagnosis involves eliciting specific construct dimensions from the client. A construct dimension usually consists of an adjective or brief phrase (for example "good," "happy," "always in a rush," and "tough as nails") and its perceived opposite (for example, "bad," "working," "lazy," and "wishy-washy"). Construct dimesnions are idiosyncratic to the persons using them; the opposite of "good" for one person may be "bad," but for another person it may be something quite different--such as "sad" or "irresponsible."

Kelly (1991b) introduced the Role Construct Repertory Test (or Rep Test) as a scientific way to elicit personal constructs. Various forms of the Rep Test have been developed, but the basic premise behind each version is the same. Client's are asked to list important figures in their lives. Then subjects are asked to take three of these figures at a time and indicate how two of them are the same and different from the third. In so doing, clients produce construct dimensions consisting of bipolar opposites (Kelly, 1991b). This can easily be done with clients, resulting in a set of specific construct dimensions that can be evaluated in a number of ways. Of course, other methods of construct elicitation have been developed. Leitner (in press) catalogues construct elicitation techniques, and provides an excellent overview of their advantages and disadvantages. The pyramid procedure, self-characterization sketch, laddering techniques, and interviewing methodologies are all described in detail (Leitner, in press). Any or all of these various techniques for eliciting constructs can be used as part of transitive diagnosis.

Recent Developments

Don Bannister did a significant amount of early work on diagnosis from a personal construct theory perspective (Agnew and Bannister, 1973; Bannister, 1968; 1985; Bannister, Salmon, and Leiberman, 1964). However, most of Bannister's writings use PCT as a means for critiquing traditional

psychiatric diagnosis. For example, Bannister, Salmon, and Lieberman (1964) tried to demonstrate empirically that nosological diagnosis fails to dictate treatment choices. They studied 1000 psychiatric hospital patients, for whom they recorded the first diagnosis and the first treatment. After analyzing their results, Bannister et al. (1964) tentatively concluded that the study's "findings were not consistent with the notion that each particular diagnosis leads logically (or habitually) to a particular treatment" (p. 731).

A later study by Agnew and Bannister (1973) employed the Rep Test to investigate the usefulness of traditional diagnosis. Eight psychiatric consultants were used as subjects. Each chose twenty patients they knew well; these patients were divided into two groups of ten (group A and group B). Agnew and Bannister (1973) asked the consultants to rank order patients in group A along eight psychological constructs (generous, obstinate, considerate, reserved, unreliable, likeable, mature, submissive) and to rank order patients in group B along eight psychiatric diagnoses (neurotic depression, personality disorder, schizophrenia, anxiety state, psychotic depression, hysteria, brain damage, and obsessional neurosis). One month later, the consultants repeated this procedure, only this time they rank ordered the patients in group A along the psychiatric diagnoses and the patients in group B along the construct dimensions. They rated the diagnoses and constructs according to interjudge

agreement, stability over time, intercorrelations between the constructs and diagnoses, and patterns of interrelationships between terms. Agnew and Bannister concluded that their "results indicate that the psychiatrists are no more stable and have no greater interjudge agreement in using diagnostic terms than they achieve with everyday language" (p. 73). In their view "psychiatric nosology is not a true specialist language" (p. 73).

Bannister (1985) incorporated the sociality corollary into a study that examined how the degree to which psychiatrists take into account the patient's point of view impacts on the patient's recovery. The sociality corollary holds that "to the extent that one person construes the construction processes of another, he may play a role in a social process involving the other person" (Kelly, 1991a, p. 66). In other words, the roles people play in relation to one other are influenced by the expectations that people have about one another. Bannister (1985) found that when the hospital agreed with patients about the cause of patient problems, both the patient and hospital tended to agree about the appropriate treatment. Type of treatment was not related to positive or negative patient outcome, but agreement about cause of the problem was. Bannister (1985) also found that hospitals generally attributed patient problems to internal causes. Consistent with the above mentioned finding, when patients attributed their problems to internal causes the outcome of their hospitalization was more likely to be

positive. Bannister (1985) concludes that it is very important for mental health professionals to keep in mind the patient's explanation of his or her problems because understanding these problems from the patient's perspective appears to greatly impact on treatment effectiveness. Keeping with Bannister's findings, transitive diagnosis emphasizes understanding the patient's constructions of the problem.

Bannister's work critiqued traditional forms of diagnosis, but little research or elaboration has been done on Kelly's original formulation of transitive diagnosis. A number of articles have called for personal construct therapists to develop and use transitive diagnosis in evaluating clients (Epting & Leitner, 1992; Raskin & Epting, 1993). In fact, Faidley and Leitner (1993) have recently made an effort to expand transitive diagnosis beyond Kelly's original formulations. Faidley and Leitner (1993) critique DSM-III-R, arguing that it is often inconsistent with particular theoretical orientations. Further, they argue that thinking about client behaviors in terms of their personal meanings is more fruitful than thinking about client behavior in terms of observable symptoms and concrete categories. Focusing on client constructions, client behaviors, process variables, and the relationship between client and therapist are all part of Faidley and Leitner's (1993) approach. Important elements of Landfield and Epting (1987) and Faidley and Leitner's (1993) work which add to

Kelly's (1991b) original formulation of transitive diagnosis are briefly summarized below.

A transitive diagnosis framework. Kelly (1991a) cautioned against placing too great an emphasis on reliability; a highly reliable instrument may simply be one that is insensitive to change (Landfield & Epting, 1987). In other words "the construct scientist seeks the primary consistency of his tests at the level of whole dimensions of personal meaning rather than in how persons specifically apply their dimensions to self and others at a particular moment in time" (Landfield & Epting, 1987, p. 92). Faidley and Leitner (1993) echo this sentiment by moving away from a primary focus on diagnostic reliability and discussing what they see as the critical components of transitive diagnosis. They believe that in order to be valid, transitive diagnosis should provide useful and rich information, be susceptible to change, emphasize process over category, and accurately reflect the client's meanings. Again, in order to meet these demands, assessment becomes a continual process; it does not end with the assignment of a disorder.

Construct interpretation. Landfield and Epting (1987) posited twenty construct interpretation guidelines. Faidley and Leitner (1993) incorporate fifteen of these guidelines into the process of transitive diagnosis. Several of these guidelines warrant mention here in order to give the reader a feel for how constructs can be interpreted and evaluated in transitive diagnosis.

Looking at a client's construct dimensions as contrasting part of his or her personality is one way to interpret constructs. Faidley and Leitner (1993) observe that "contrasts that appear incredulous to the clinician may, in fact, be opposites for the client" (p. 61). As an example of this, they discuss a man who possessed the construct dimension of "depressed vs. irresponsible." Most people would not see "irresponsible" as the opposite of "depressed." However, in this man's construction of reality, such a dimension was very powerful; when he was promoted at work, the perceived responsibility led him to attempt suicide (Faidley and Leitner, 1993). Landfield and Epting (1987) do a nice job presenting unique construct dimensions that people hold; in so doing, Landfield and Epting (1987) clarify the idiographic nature of personal constructions.

Constructs can also be used to hypothesize about how clients will behave in the future. For example, Faidley and Leitner (1993) mention a client who holds the construct "passive/murderous." The dominant pole of the construct may be "passive," but the therapist can use the "murderous" pole as a barometer of what to expect if the client shifts away from the "passive" pole; this construct dimension alerts the therapist "to the possibility of violent, even murderous, behavior should the client become less 'passive'" (Faidley & Leitner, 1993, p. 62).

Observing how often a client overuses a construct can provide therapeutic insight, as can attention to how often

client's describe social interactions (Landfield & Epting, 1987; Faidley & Leitner, 1993). In addition, therapists should focus on how open constructs are to accommodating new experiences; people who lack constructs of change are likely to be less amenable to change. Identifying constructs that deal with death, destruction, depression, and maladjustment can also be useful to therapists, as can identifying constructs that indicate alienation--such as "don't care," "uninterested in life," and "self-rejecting" (Landfield & Epting, 1987; Faidley & Leitner, 1993). Attention to descriptive modifiers that clients use is also important.

> Constructs modified by words like "always," "never," "very," "absolutely," or "perfectly" may be ones that represent more significant and core understandings. An excessive use of extreme modifiers may signal a constricted approach to relating or problem solving. (Faidley & Leitner, 1993, p. 66)

Likewise, overuse of modifiers such as "sometimes," "a bit," and "somewhat" may suggest decision-making difficulties (Faidley & Leitner, 1993).

If a client only supplies one pole of construct dimension, it may indicate that he or she is trying to avoid something; in such cases, the therapist can interpret the client's behavior as indicating some kind of threat. Finally, if therapists try to imagine client constructs as their own, they are often able to better comprehend their clients. Faidley and Leitner (1993) observe that looking at the world through the client's constructions "may be the most important for the therapist interested in understanding the client's struggles" (p. 67).

Case studies. Faidley and Leitner (1993) devote four chapters to actual case studies that employ transitive diagnosis. Each chapter presents a series of personal constructs produced by a particular client, and then presents a number of clinical hypotheses regarding those constructs. Further, interpersonal process analyses (wherein the therapist assesses the client's body language, manner of speaking, and other methods of communication) are undertaken for each client, and discussed in relationship to the constructs elicited. Finally, the fates of the various therapeutic hypotheses are presented; as therapy progressed, Faidley and Leitner (1993) explain the ways in which these hypotheses were confirmed, disconfirmed, dismissed, or altered. By presenting these case studies, Faidley and Leitner (1993) provide concrete examples of the process of transitive diagnosis.

Common Criticisms of Psychiatric Diagnosis

Issues of reliability and validity remain central to many of the debates over psychiatric diagnosis. However, many of the researchers involved in the debate over reliability and validity--even those who feel DSM-III and DSM-III-R are lacking in this regard--share an underlying belief in the value of diagnosis. Nevertheless, numerous critics have attacked what they see as the underlying theoretical flaws of psychiatric diagnosis. Because DSM has been the dominant diagnostic scheme during the past forty

years, many of the criticisms of psychiatric diagnosis have also involved criticisms of DSM (for an interesting debate on the advantages and disadvantages of DSM-III, see Klerman, 1984; Vaillant, 1984; Spitzer, 1984a; 1984b; and Michels, 1984a, 1984b). Even so, common concerns about psychological assessment are relevant for both DSM and transitive diagnosis approaches. Therefore, some of the more common controversies involving psychiatric diagnosis are presented below; specific DSM-III or DSM-III-R research is incorporated into the discussion where it is relevant in explicating these controversies.

Difficulty Identifying the Mentally Ill

Rosenhan (1973) wondered whether or not staff members could distinguish pseudopatients from other, presumably real, patients. He had eight pseudopatients--three females, five males--present themselves for admission at twelve different mental hospitals. During admission interviews, pseudopatients complained about hearing voices that said "empty," hollow," and "thud" (Rosenhan, 1973). None of the pseudopatients were detected as imposters. All were admitted to the hospital, and all but one were diagnosed with schizophrenia. The one pseudopatient not diagnosed with schizophrenia was diagnosed with manic-depressive psychosis (Rosenhan, 1973).

Once hospitalized, pseudopatients "ceased simulating any symptom of abnormality" (Rosenhan, 1973, p. 251). They

simply behaved normally. However, they were still not detected by staff members as imposters, even though none of them had any previous history of psychopathology. Interestingly, the only people who seemed to realize that the pseudopatients were imposters were the actual patients. Pseudopatients were hospitalized "from 7 to 52 days, with an average of 19 days" (Rosenhan, 1973, p. 252). Thus, pseudopatients did not go undetected because staff lacked time to observe them. Even upon release, none of the pseudopatients were detected as imposters. All eleven of the pseudopatients admitted with a diagnosis of schizophrenia were released with a diagnosis of schizophrenia "in remission" (Rosenhan, 1973).

Rosenhan (1973) offers a potential explanation for why the staff were unable to distinguish the pseudopatients from real patients, suggesting that the staff's failure was due to a bias towards Type II errors, wherein staff felt it was safer to "err on the side of caution, to suspect illness even among the healthy" (p. 252). However, a second study by Rosenhan disconfirms this explanation. Rosenhan (1973) informed the staff at a research and teaching hospital that he would send one or more pseudopatients to the hospital over the course of the next three months. During that time, hospital staff members rated all patients presenting themselves for admission on a 10 point scale. This scale assessed the confidence of staff members that a patient was a

pseudopatient. Rosenhan's (1973) results are quite informative:

> Forty-one patients were alleged, with high confidence, to be pseudopatients by at least one member of the staff. Twenty-three were considered suspect by at least one psychiatrist. Nineteen were suspected by one psychiatrist and one other staff member. Actually, no genuine pseudopatient . . . presented himself during this period. (p. 252)

The results of Rosenhan's (1973) second study indicate that Type II errors were not the primary cause of staff being unable to distinguish real patients from pseudopatients. Staff members were just as easily influenced towards diagnosing real patients as pseudopatients as they were towards diagnosing pseudopatients as real patients. Essentially, hospital staff members were unable, in either of Rosenhan's studies, effectively to distinguish the mentally ill from "normal" people. While Rosenhan's (1973) results do not necessarily generalize to DSM-III-R or transitive diagnosis, and alternative explanations for Rosenhan's (1973) results are possible, his study is important because it makes clear the need to have a diagnostic system that distinguishes disordered from normal people.

Mental illness As Myth

One of the most vociferous critics of mental illness and psychiatric diagnosis during the past three decades has been Thomas Szasz (1960, 1963, 1974, 1987, 1991). Szasz attacks medical model approaches to abnormal behavior, arguing that "mental illness" is a metaphorical term, since the mind

cannot become physically sick. According to Szasz, an illness requires a corresponding biological dysfunction. The term "mental" does not correspond to any physical structure of the body. Thus, Szasz (1974, 1987) argues that one cannot actually have a mental illness; that is, mental illness, in a literal sense, does not exist. In Szasz's (1974) words: "'Mental illness' is a metaphor. Minds can be 'sick' only in the sense that jokes are 'sick' or economies are 'sick'" (p. 267).

Szasz maintains that people are either physically sick or not. In many cases, the etiology of particular categories of mental illness is not known. Szasz argues that many mental illnesses of unknown etiology are probably not illnesses at all in that they are not biologically caused. Rather, they constitute "problems in living." It is irresponsible, in Szasz' (1974, 1987) view, to insist that misunderstood and socially undesirable behaviors are known mental illnesses, when these behaviors are not necessarily illnesses at all. While Szasz is perhaps the best known critic of the medical model, others have expressed dissatisfaction with applying the medical model in a psychological context (Breggin, 1991; Laing, 1965, 1967).

Szasz (1974, 1987) is concerned with psychiatric diagnosis based upon the medical model. Because Szasz feels that mental illness is a metaphorical term, he argues that a medical model approach in diagnosing deviance is inappropriate. For Szasz, most abnormal behavior cannot be

successfully approached from the standpoint of the medical model. He does not deny that people often exhibit behavior patterns which deviate from societal norms, are difficult to understand, and are sometimes a source of unhappiness for those engaging in them. Instead, he argues that the categories used to describe these behavior patterns, though called illnesses, are often merely descriptions (Szasz, 1974, 1987). Szasz makes this clear in his critique of DSM diagnosis, which he sees as theoretically tied to the medical model of abnormality.

According to Szasz (1960, 1974, 1987), the problem is not simply the creation of diagnostic categories; the problem is that these metaphorical illness labels have ceased to be viewed as descriptors and have come to be viewed as biological disease entities. Furthermore, Szasz (1987) maintains that DSM, in all of its versions, is not truly a scientific enterprise. DSM categories do not describe scientifically valid diseases; they are categories devised, and continually revised, by committees. Controversial diagnoses--such as homosexuality, paraphilic rapism, premenstrual syndrome, and self-defeating personality disorder--are included or excluded from each successive version of DSM more for political than scientific reasons (Szasz, 1987; for an excellent chronicling of the complicated political battles surrounding some of these diagnoses, see Kirk & Kutchins, 1992). Szasz (1987) angrily complains that instead of a scientifically legitimate diagnostic system, in

DSM "we have psychiatric democracy" (p. 80), where diagnostic categories are based more on political consensus than scientific discovery. Robert Spitzer, head of the DSM-III and DSM-III-R task forces, echoes Szasz's complaint when he laments that expert consensus, rather than empirical data, will be used to make final decisions about DSM-IV (Spitzer, 1991).

Labeling Theory and Mental Illness

Concern over the stigma of mental illness is not new. Goffman (1961, 1963) looked at stigma in general, and specifically at the way mental patients become stigmatized during the process of hospitalization. His analysis addressed the impact "total institutions" (such as mental hospitals) have on inmates, and was quite influential in the deinstitutionalization movement. Addressing diagnosis more specifically, Thomas Scheff (1966) developed labeling theory--which argues that being labeled as mentally ill has powerful consequences. Scheff speaks of "residual deviance," which involves deviant behaviors for which society lacks a specific, legally sanctioned response. Most of the time, residual deviance is not addressed by society. When society does respond to residually deviant behavior, labeling of the deviant person occurs. For Scheff (1966), deviant persons are often labeled as mentally ill and given psychiatric diagnoses. These diagnoses influence the way others perceive and respond to labeled persons. As a result, societal forces

impact on labeled individuals, causing them to alter their self-perceptions and behaviors. Ultimately, labeled individuals come to behave in ways that are consistent with the diagnoses they are assigned. This has potentially important consequences for categorical diagnosis which, if labeling theory is correct, results in stigmatization for those diagnosed.

Research on Scheff's theory has produced mixed results. For comprehensive reviews of labeling theory research, see Gove (1980) and Link and Cullen (1990). Here, discussion of a few studies will have to suffice. One early study used to support labeling theory was performed by Phillips (1963), who found that seeking psychiatric help for mental illness results in rejection by others. Farina, Gliha, Boudreau, Allen, and Sherman's (1971) research indicated that mental patients are affected by other people being aware of their status as mental patients. In the research of Farina et al. (1971), mental patients who were informed that a confederate knew of their mental illness status had a significantly harder time performing a task than control subjects. Further, observers rated subjects who believed others knew of their mental illness status as more tense and less well adjusted than they did control subjects. The findings of Farina et al. (1971) lend support to the idea that psychiatric labels influence the behavior of those labeled.

More recently, Socall and Holtgraves (1992) found that people were less willing to interact with a person when the

person was labeled as mentally ill than when that same person was labeled as physically ill. Gallop, Lancee, and Garfinkel (1989) found that nurses respond to hypothetical statements about borderline personality disorder patients differently than they do to schizophrenic patients; nurses react in a more emotionally involved way in response to schizophrenic patients, but tend to be demeaning and contradictory in response to borderline patients. This suggests that different disorders can result in different labeling effects.

Not all research has fully supported labeling theory. For example, studies by Chassin, Presson, Young, and Light (1981) and Holman and Caston (1987) provide only slim to moderate support for labeling theory. Warner, Taylor, Powers, and Hyman (1989) conducted a study that disconfirmed one of labeling theory's most central predictions; their study's results showed that acceptance of a mental illness label does not produce lower levels of functioning. In other words, subjects in the study by Warner et al. (1989) who accepted their diagnoses did not exhibit more deviant behavior than subjects who rejected their diagnoses. This contradicts Scheff's (1966) idea that a person assigned a mental illness label will come to behave in accordance with the label. However, the results of Warner et al. (1989) did confirm certain aspects of labeling theory. It was found that acceptance of a mental illness diagnosis results in lower self-esteem when high levels of stigma are associated with it. Further, Warner et al. found that acceptance of a

mental illness label is positively correlated with an attribution of external locus of control. Thus, the study by Warner et al. (1989) provides mixed support for labeling theory.

Rabkin (1984) contends that while stigma regarding mental illness should not be overlooked, labeling approaches overestimate the degree to which people are rejected based on an identification as mentally ill. She discusses a field study in Toronto, a telephone survey in New York City, and a survey in Oklahoma that all examined the degree to which a mental illness label results in stigma. The three studies found that people often do not know that they live near psychiatric facilities, but are not upset about it when they do know. Rabkin (1984) concludes that deviant behavior is more important in rejection of the mentally ill than are labels; further, she sees societal attitudes towards the mentally ill changing in a positive direction. Brockington, Hall, Levings, and Murphy (1993) found that certain factors were correlated with more positive responses to the mentally ill. In their study, association with a mentally ill person enhanced tolerance of the mentally ill. Brockington et al. (1993) also found being young, having more education, and having a higher level managerial job were associated with greater tolerance. In addition, they found that people in a town served by a mental hospital were slightly less tolerant of the mentally ill than people in a town served by a community-based mental health service.

Gove (1980) provides a sophisticated critique of Scheff's approach, one which questions the basic premises behind labeling theory. He states that the labeling perspective fails to see "the deviant as someone who is suffering from an interpersonal disorder, but instead as someone who, through a set of circumstances, becomes publicly labeled a deviant and who is forced by societal reaction into a deviant role" (p. 85). Gove (1980) rejects this idea. He cites evidence showing that, of those identified as mentally ill, "a substantial majority have a serious disorder quite apart from any secondary deviance" (p. 85). To Gove (1980), deviant behavior, rather than a deviant label, is what causes people to respond negatively. He criticizes labeling theory research for failing to distinguish what it is that makes people respond negatively to labeled persons. Link and Cullen (1990), in their review of labeling theory research, cite a number of studies which indicate that deviant behavior, not labeling, is primarily responsible for rejection of the mentally ill. In addition, Link, Cullen, Frank, and Wozniak (1987) present a table summarizing twelve previous studies that investigated whether labeling or deviant behavior was more important in influencing perceptions of mental patients. Ten of the studies found deviant behavior to be more influential than labels (Link et al., 1987). Such findings support Gove's (1980) criticism of labeling theory. However, a recent study by Burk and Sher (1990) found that both mental health professionals and peers

rated persons labeled as children of alcoholics more negatively than those not labeled as such, regardless of whether the labeled person was described as socially successful or having behavior problems.

In response to Gove's (1980) criticisms, Bruce Link and his colleagues have developed a revised labeling theory, which holds that socialization creates a set of beliefs about mental patients, and that when someone becomes a mental patient these beliefs become salient. In this revised formulation, labeling has negative consequences when labeled individuals believe that others will discriminate against them based on their status as mental patients (Link, Cullen, Struening, Shrout, and Dohrenwend, 1989). This revised approach challenges Gove's (1980) assertion that behaviors, not labels, are most critical in stigmatizing mental patients. In a vignette study, Link et al. (1987) found an interaction between beliefs about how dangerous the mentally ill are and labeling. That is, they found that people who perceive the mentally ill as dangerous are more likely to respond negatively to a person with a mental illness label. Further, Link et al. (1987) found that being perceived as dangerous was actually more important in predicting negative responses to a labeled person than behavior. This study confirms a revised labeling approach's hypothesis that labels matter, if they activate certain expectations about the labeled person.

Other studies by Link and his colleagues have supported their revised labeling theory formulations. For example, Link (1989) found that labeled persons who believe that mental illness diagnoses will lead to discrimination and devaluing are more likely to report loss of income, unemployment, and feelings of demoralization than nonlabeled persons with the same beliefs. Again, this seems to indicate that beliefs about the consequences of a label influence the way such a label affects self-perceptions and behavior. Link et al. (1989) found similar results; their research indicates that both mental patients and untreated community residents believe that mental patients are rejected by most people. Patients supported using withdrawal, secrecy, and education to cope with expectations of rejection (Link et al., 1989). More ominously, Link, Mirotznik, and Cullen (1991) found that patients who try to escape labeling effects by keeping their patient status a secret, avoiding situations potentially leading to rejection, and teaching others about their disorders fail to avoid the negative consequences of labeling. In fact, the results of Link et al. (1991) showed that trying to avoid labeling effects was more harmful than beneficial.

Other Labeling-Related Research

Other studies that have investigated the impact of psychiatric diagnoses on perceptions of persons have yielded interesting results. While related to the labeling theory

research, the studies presented below are not explicitly rooted in a labeling theory approach but are still highly relevant for determining the impact of diagnostic labels on perceptions of self and others.

Mindfulness. Langer and Abelson's (1974) research is most directly related to labeling theory research. Langer (1989) distinguishes between mindfulness and mindlessness. Mindlessness occurs when we rigidly adhere to the categories we have created. Mindfulness involves incorporating new information into what is already known, as well as the acceptance of multiple views of the same event (Langer, 1989). Langer and Abelson (1974) investigated the ways in which labels impact on clinicians. Two groups of clinicians participated in the study. One group was trained according to a psychoanalytic model, which included acceptance of traditional approaches to psychiatric diagnosis and labeling; the other group was trained according to a behavioral model, which "typically includes severe skepticism about the utility of diagnostic categories and labels" (Langer & Abelson, 1974, p. 5). All clinicians watched a fifteen minute videotape of a young man discussing his past work experiences. When labeled a "job applicant," clinicians generally rated the young man as fairly well adjusted, theoretical orientation notwithstanding. However, when labeled a "patient," analytic clinicians rated the young man as significantly more disturbed than when he was labeled a "job applicant." By comparison, behavioral clinicians rated the young man as

fairly well adjusted regardless of his label. Thus, theoretical orientation may influence the ways in which clinicians apply any given diagnostic system.

The impact of the young man's label becomes even more striking when assessments of him by the analytic clinicians in the two experimental conditions are compared. In the "job applicant" condition, analytic clinicians described the young man as "'attractive and conventional looking'; 'candid and innovative'; 'ordinary, straightforward'; 'upstanding, middle-class citizen type, but more like a hard hat'; 'probably of lower or blue-collar origins'; 'middle-class protestant ethic orientation; fairly open--somewhat ingenious'" (Langer & Abelson, 1974, p. 8). In the "patient" condition, analytic clinicians described the same young man as a "'tight, defensive person . . . conflict over homosexuality'; 'dependent, passive-aggressive'; 'frightened of his own aggressive impulses'; 'fairly bright, but tries to seem brighter than he is . . . impulsivity shows through his rigidity'; 'passive, dependent type'; 'considerable hostility, repressed or channeled'" (Langer & Abelson, p. 8).

Further, when asked whether or not the young man's life outlook was realistic, analytic clinicians in the "patient" condition generally seemed to view the young man's outlook as less realistic than analytic clinicians in the "job applicant" condition. This study's results suggest that labels and theoretical preconceptions can indeed bias the way clinicians perceive clients. Langer and Abelson (1974)

question the very necessity of psychiatric diagnosis as currently practiced, noting that "if the therapist were not given the patient label, he would see a very different range of behaviors or attribute the given behaviors to factors other than the patient's 'illness'" (p. 9).

A second study by Langer further investigated the impact of labels, this time on laypersons. The study showed that even mindful perceptions can be inappropriate when it comes to assessing deviance. In this study, subjects viewed a videotape of a person who was identified as either an ex-mental patient, a homosexual, a divorced person, a cancer victim, or a millionaire (Langer & Imber, 1980). Subjects provided with such information were considered mindful because the novelty of the label was expected to increase the accuracy with which they perceived the videotaped person. A sixth mindful group of subjects was asked to attend to the videotaped person's physical appearance. A seventh group of subjects constituted the mindless control group; these subjects were not given any information about the videotaped person, nor were they told to attend to anything in particular about the subjects

Results indicated that subjects from all of the mindful groups, including those asked to attend to the physical characteristics of the videotaped person, more accurately perceived the videotaped person's characteristics than the mindless subjects (Langer & Imber, 1980). However, mindful subjects also rated the videotaped person's characteristics

as significantly more extreme and atypical than the mindless subjects. The very distinctiveness that is seen in others when one mindfully attends to them is often interpreted as deviance. Langer and Imber's (1980) research suggests that in making psychological diagnoses of any kind, it is important to be aware of tendencies to evaluate distinctive behavior as more deviant than it actually is. Ridding ourselves of underlying biases is also necessary, since inappropriate mindful evaluations "can be used to confirm hypotheses that may be used as justifications for differential treatment. Furthermore, mindful evaluations of nondeviants may lead to assumptions of deviance also resulting in prejudicial behavior" (Langer & Imber, 1980, p. 366).

Suggestion effects. Temerlin (1968, 1970) conducted a study in which the effects of diagnostic suggestion were evaluated. Clinical psychology graduate students, clinical psychologists, and psychiatrists were used as subjects; all were shown a videotape of a patient. Three clinical psychologists had previously viewed the tape, and judged the patient mentally healthy. However, prior to watching the videotape, experimental subjects were told by a prestigious confederate that the patient "was 'a very interesting man because he looks neurotic, but actually is quite psychotic'" (Temerlin, 1968, p. 350). Four control groups were used. In none of these control groups was it suggested to subjects that the videotaped man was psychotic. After watching the

videotape, subjects in all groups were asked to diagnose the patient from a counterbalanced list of various psychoses, neuroses, and miscellaneous personality disorders, including "normal or healthy personality." The prestigious confederate's suggestion had a significant impact on experimental subjects' diagnoses. None of the subjects in any of the four control groups diagnosed the patient as psychotic. However, in the experimental group, 60 percent of the psychiatrists, 28 percent of the clinical psychologists, and 11 percent of the graduate students diagnosed the patient as psychotic (Temerlin, 1968). In thinking about DSM-III-R and transitive diagnosis, it is important to consider the degree to which clinicians can objectively evaluate patients; further, consideration of factors that might influence the diagnostic process--such as the impact of diagnostic suggestion--is quite important.

Problem-centered approach. Two studies performed in the early 1960s by Paul Rothaus and his colleagues compared reactions to mental patients who describe their psychopathology in problem centered terms to mental patients who describe their psychopathology in mental illness terms. In the first of these studies, patients in a Veterans Hospital engaged in a role play which simulated a job interview (Rothaus and Morton, 1962). Some of the patients were assigned the role of interviewer and the other half assigned the role of job applicant. Each interviewer-applicant team role played the interview twice; one time the

applicant described his reason for being in the hospital as mental illness, and the other time he described it as a problem in getting along with people. Results indicated that job interviewers responded more positively to the applicant when the applicant's problem was presented in problem-centered terms rather than mental illness terms (Rothaus and Morton, 1962).

A second study replicated the first, except this time thirty-two real job interviewers from the Texas Employment Commission were used (Rothaus, Hanson, Cleveland, and Johnson, 1963). Sixteen mental patients were trained in presenting themselves in mental illness terms and problem-centered terms. Patients met separately with two interviewers, using the problem-centered approach in one interview and the mental illness approach in the other. Job interviewers in the problem-centered condition received written information about the patient that explained the patient's entry into the hospital as due to "problems in his everyday interpersonal relationships" (Rothaus et al., 1963, p. 86). Job interviewers in the mental illness condition received written information about the patient that explained the patient's entry into the hospital as due to "trouble with his nerves" (p.86). In the problem-centered condition, patients described themselves as having had difficulty in social relationships and explained that their hospitalization had taught them how to solve their problems. In the mental illness condition, patients described themselves as having

had a nervous breakdown and explained that their hospitalization and medication had resulted in a cure (Rothaus et al., 1963). Interviewers rated the degree to which they felt they could place each patient in a job. Interviewers rated each applicant twice, once after reading the written description and once after the personal interview.

Results indicated that job interviewers rated patients more positively, and therefore easier to place in jobs, when patients explained their hospitalization in problem-centered terms as opposed to mental illness terms. Further, in both the mental illness and problem-centered conditions, Rothaus et al. (1963) found that interviewers rated applicants more positively after having met with them in person. In fact, differences in ratings of patients in the mental illness and problem-centered conditions only occurred after the in person interview; no differences in interviewer ratings of the job applicant were found based on mental illness or problem-centered written descriptions alone. Rothaus et al. (1963) hypothesize that "getting to know" someone with a psychological problem often helps dispel preconceptions. Further, their study's results suggest that the way patients present themselves and their problems to others has an effect on the way others react to them. In thinking about psychiatric diagnosis, it seems important to weigh the different impressions people receive from various ways of describing particular disorders.

Sexism and Diagnosis

DSM-III and DSM-III-R have often been accused of being biased against women. For example, Loring and Powell (1988) found that both sex of client and sex of psychiatrist influenced the way diagnoses were assigned when using DSM-III-derived criteria. They found that male clinicians are more likely to diagnose white women patients as depressed and black women patients as having paranoid personality disorders than are female clinicians (Loring & Powell, 1988). In addition, Loring and Powell (1988) found that when diagnosing white women patients, white women psychiatrists tend to assign less severe diagnoses. Despite this one exception for white women clinicians diagnosing white women patients, psychiatrists tended to diagnose a patient most accurately when the patient's sex and race were identical to the psychiatrists. Further, Loring and Powell (1988) found that psychiatrists' diagnoses had a higher degree of reliability and accuracy when made without knowledge of a patient's sex or race. The important question that remains to be answered is whether DSM-III-R itself is sex biased, or whether DSM-III-R categories are fairly objective and unbiased but assigned in a sex biased manner in real world scenarios.

Russell (1985) argues against DSM-III because she sees its psychiatric diagnoses as oppressing women in a number of specific ways. She critiques DSM-III, which she feels contains subjective value judgments regarding pathology which

are often sexist. She cites the now classic study by Broverman, Broverman, Clarkson, Rosenkrantz, and Vogel (1970), which found that clinicians' conceptions of a typical, mentally healthy adult conformed to expectations of a typical, mentally healthy male but were significantly different from conceptions of a typical, mentally healthy female--implying that women are likely to be seen as less well adjusted than men. Russell (1985) contends that Western conceptualizations of pathology are similar to Western conceptualizations of the traditional female role. For example, dependent personality disorder is described as involving the impairment of independent functioning, an inability to take responsibility for major life areas, the subordination of one's own needs, and low self-confidence. Russell (1985) comments:

> All this has a familiar ring. It is very close to what we are expected to be as women. If we succeed in our role as women then we may be diagnosed as having a personality disorder. If we do not succeed in our role as women, we will be punished in other ways. (p. 303)

DSM-III, in Russell's view, reflects the sexism inherent in society.

There has been a fair amount of empirical research regarding sexism in diagnosing abnormality. Rosenfield (1982) provides evidence that assessments of deviance are influenced by sex role norms and that they can be harmful for both men and women. She examined the records of patients entering a psychiatric emergency room and found that patients who exhibited "deviant deviance" by engaging in abnormal

behaviors which ran counter to traditional sex role norms had significantly higher rates of hospitalization than patients whose abnormal behaviors were consistent with traditional sex role norms (Rosenfield, 1982). More specifically, Rosenfield (1982) found that males diagnosed with disorders predominantly identified in females--such as neurotic or psychotic forms of depression--were significantly more likely to be hospitalized than were similarly diagnosed females. On the other hand, females diagnosed with disorders predominantly identified in males--such as personality and substance abuse disorders--were significantly more likely to be hospitalized than were similarly diagnosed males. No significant differences in rate of hospitalization were found for subjects diagnosed with disorders in which neither sex is typically predominant. Rosenfield (1982) concludes that "males are more often hospitalized for 'feminine' types of disorders than are females. Females are more often hospitalized for 'masculine' types of disorders than are males" (p. 22).

Rosenfield (1982) observes that the findings might be due to the fact that males and females exhibiting abnormal behavior inconsistent with sex role norms are generally more severely disturbed than others, thus explaining their higher rates of hospitalization. While further studies seem necessary in order fully to determine whether or not this is so, Rosenfield negates this explanation to some extent by noting that the number of subjects exhibiting "deviant

deviance" who were diagnosed as severely disturbed did not differ significantly from the number of subjects whose abnormality was consistent with sex role norms. Thus, Rosenfield feels that severity of impairment does not explain the results of this particular study.

Brown (1990) reports that female military veterans are less likely to be diagnosed with posttraumatic stress disorder than their male counterparts; such women are often misdiagnosed with personality disorders. Similarly, Caplan (1992) notes that learning disabilities are diagnosed far more often in boys, even though recent research indicates that such disorders occur equally in both boys and girls. While diagnostic bias does happen, it is unclear how much DSM-III-R is to blame. An objective manual in a sexist society is bound to be used in sex biased ways.

Caplan (1992) does not believe that DSM-III-R is objective; she sees a great deal of sexism in it. She expresses particular concern over two new diagnoses contained in DSM-III-R that she believes are sexist: self-defeating personality disorder and late luteal phase dysphoric disorder. Self-defeating personality disorder applies to the battered wife who remains within an abusive relationship. Caplan (1992) feels this diagnostic category is dangerous "because it leads both therapists and the women so diagnosed to believe that the problems come from within, that the women have a sick need to be hurt, humiliated, unappreciated, etc." (p. 75). Late luteal phase dysphoric disorder involves

emotionality resulting from premenstrual syndrome. Caplan (1992) argues that classifying premenstrual syndrome as a mental disorder can easily be used "to justify keeping women out of well-paying, responsible jobs" (p. 76). She adds that extremely masculine behaviors are not considered disorders; for example, there is no "Macho Personality Disorder" or "Testosterone-Based Aggressive Disorder" (Caplan, 1992). In Caplan's (1992) view, DSM-III-R diagnosis is extremely biased against women. She concludes that "the human and clinical applications of biased categories need rapid and radical transformation" (p. 78).

Racism and Diagnosis

Controversy over the effect of race on diagnosis has not been resolved, since interpretations of the studies done in this area vary. Fernando (1993) points out that the history of psychiatry has been influenced by racist trends in Western culture, and Worthington's (1992) review of empirical research conducted between 1965 and 1991 does seem to indicate that diagnosis is often biased along racial lines. Rosenfield (1984) conducted a study that investigated the impact of racial bias in diagnosis and treatment of the mentally ill. She found that non-white males are involuntarily hospitalized more often than their white counterparts. However, she concluded that whites are less stigmatized by mental disorder diagnoses and hospitalized less often because "the more coercive conditions under which

nonwhites enter treatment determine the more severe responses to nonwhites' deviance" (Rosenfield, 1984, p. 21). Thus, racial biases within the DSM-III and DSM-III-R diagnostic systems may not be the primary reason that whites and non-whites are treated differently with regard to diagnosis and hospitalization; rather, accurate DSM-III-R diagnoses may simply be applied in a racially biased manner.

Loring and Powell's (1988) previously mentioned study directly addressed the impact of race on diagnosis of mental disorders, and found that more severe diagnoses are often assigned to African Americans. More specifically, they found that race had an effect on the diagnoses assigned to African Americans, especially African American males. For example, Loring and Powell (1988) discovered that African American males are more likely to be diagnosed with a paranoid schizophrenic disorder than are other patients. Further, African Americans, regardless of sex, are more likely to be diagnosed with paranoid personality disorders than are white patients. In general, Loring and Powell (1988) found that "clinicians appear to ascribe violence, suspiciousness, and dangerousness to black clients even though the case studies are the same as the case studies for white clients" (p. 18). In their study, diagnostic bias according to race occurred even when the clinicians making the diagnoses were African Americans; that is, even African American clinicians were more likely to diagnose African American males as suffering from paranoid schizophrenic disorders. Again, whether the

occurrence of racial bias is due to DSM diagnosis itself or the effects of societal biases on the way diagnoses are assigned is unclear.

Other research supports Loring and Powell's (1988) findings. Pavkov, Lewis, and Lyons (1989) conducted a logistic regression analysis on the types of diagnoses assigned severely disturbed people, and found that being African American predicts a schizophrenic diagnosis. Lawson, Hepler, Holladay, and Cuffel (1994) examined census data from the Tennessee Department of Mental Health for 1984 and 1990. Results indicated that African Americans were overrepresented in public inpatient facilities compared to their proportion in the population. Further, Lawson et al. (1994) "found that African Americans were overrepresented among patients with a diagnosis of schizophrenia" (p.73) and that "African American inpatients were overrepresented in most other diagnostic categories as well" (p. 73). Lawson et al. (1990) point out that DSM-III-R was throughout Tennessee in 1990, implying that it was used in a racially biased manner, if not racially biased itself.

Neighbors, Jackson, Campbell, and Williams (1989) reviewed literature on racism and diagnosis, and concluded that such research makes one of two contradictory assumptions. Some researchers assume that African American and Caucasian persons exhibit similar symptoms when afflicted with a disorder, but that these symptoms are perceived as different by clinicians. Other researchers assume that

African American and Caucasian persons actually do exhibit symptoms differently, but that clinicians lacking cross-cultural knowledge are not sensitive to these differences. Neighbors et al. (1989) suggest that structured interview research might help clarify controversy surrounding race and diagnosis. However, they observe that the DSM-III-R diagnostic criteria used in structured interviews were "compiled by clinicians working with predominantly white patient populations. Thus, one could argue that we are merely replacing one biased system with another" (Neighbors et al., 1989). Despite this concern, Neighbors et al. (1990) believe that epidemiological research on mental disorders and how they affect both African Americans and Caucasians can better help researchers to understand how race issues impact on diagnostic inferences.

Culture bias. Rothblum, Solomon, and Albee (1986) argue that DSM diagnosis fails to consider sociocultural factors, and therefore takes behaviors that are socially deviant and transforms them into diseases. For example, Rothblum, Solomon, and Albee (1986) feel that men who rape women or abuse children are often diagnosed with personality disorders. However, they contend that sociocultural factors influencing these men's behavior, such as the sexist nature of American society, are overlooked in DSM-III. The issue of whether DSM-style diagnosis can be generalized across cultures is a controversial one. Brown (1990) argues that client assessments often fail to take culture into account.

However, research by Martin and Grubb (1990) implies that taking culture into account does not necessarily lead to avoidance of culture biased diagnoses. They found that white juvenile offenders are often perceived as having a psychological disorder, whereas black juvenile offenders are often perceived as behaving in culturally expected ways. Cohen and Carlin (1993) also found culture to be important in diagnosis. Their research indicated that African Americans and Caucasians diagnosed with dementia often show differences "in behavioral and cognitive symptomatology" (p. 383). Cohen and Carlin (1993) appear to perceive such differences as due more to sociocultural influences on the way dementia is manifested than in diagnostic bias within DSM-III-R.

Criticisms of Diagnosis in Relation to the Present Study

While criticisms of psychiatric diagnosis as sexist, racist, and culturally biased can appear quite convincing at times, it is important to remember that these criticisms may simply indicate that the society from which current diagnostic manuals came is sexist, racist, and culturally biased in ways of which it is often unaware; based on the contradictory studies in this area, whether or not these biases have influenced DSM in its various forms is not entirely clear. Those who favor DSM-style diagnosis convincingly argue that if racial, cultural, and gender biases can be eliminated, then a truly objective, reliable, and valid diagnostic manual can be created. Further, it can

be argued that DSM is not biased, but simply applied in biased ways. On the other hand, those who question DSM-III-R diagnosis often wonder whether or not researchers in favor of categorical diagnosis can free subsequent revisions of DSM from societal biases and produce a truly objective diagnostic system.

The ability to produce an objective, categorical system of diagnosis is a crucial area of debate between those in favor of DSM-III-R diagnosis and those who oppose it; firm consensus on this issue has yet to be reached. Those who develop alternatives to DSM, such as Faidley and Leitner (1993) need to be aware of the many complex issues involved in creating any diagnostic system. Sexism, racism, culture bias, labeling effects, and underlying theoretical assumptions all impact on the system of diagnosis that one creates. If each of these issues is not addressed in a cogent fashion, the resulting diagnostic scheme is bound to suffer. Herein, an initial attempt is made to investigate labeling effects by assessing the impact of DSM-III-R and transitive diagnoses on perceptions of a person with a psychological problem.

Hypotheses and Overview of the Study

A vignette study, in which three DSM diagnoses were presented in DSM form as well as translated and presented in transitive diagnosis form, was performed in order to compare the reactions of laypersons to DSM-III-R diagnoses and

transitive diagnoses. Laypersons were used as subjects rather than mental health professionals because laypersons generally have little knowledge about either DSM-III-R diagnosis or transitive diagnosis. Had mental health professionals been used, they would generally have been familiar with DSM-III-R diagnosis and unfamiliar with transitive diagnosis. This might have influenced their responses. Layperson subjects, by comparison, provided the opportunity to examine the ways in which DSM diagnosis and transitive diagnosis impact on people who possess little or no knowledge of either.

While the research literature is inconclusive regarding the effects of labels, a substantial number of studies indicate that labels influence the ways in which we perceive others (Burk & Sher, 1990; Kus & Carpenter, 1991; Langer & Abelson, 1974; Langer & Imber, 1980; Link, 1987; Link & Cullen, 1990; Link et al., 1987; Link et al., 1989; Link et al., 1991; Scheff, 1966). In the present study, it was predicted that DSM diagnosis and transitive diagnosis would create different perceptions of a diagnosed person. DSM diagnosis, as a result of its emphasis on labeling and treatment, was expected to make people desire greater social distance from those diagnosed than is transitive diagnosis.

> Hypothesis 1: Subjects who read a brief description of a man will desire greater social distance from the man when the man is described as having a past psychological problem and given a DSM-III-R diagnosis than when the man is described as having a past psychological problem and given a transitive diagnosis. Further, it is predicted that subjects will desire the least social

distance from the man when the man is not described as having a psychological problem at all.

Using a series of bipolar adjectives, Burk and Sher (1991) found that mentally ill teenagers were generally rated as more sad, weak, rebellious, abnormal, nervous, rejected, rough, bad, unfriendly, inactive, and unable to control their behavior than "typical" teenagers. In the present study, it is hypothesized that a similar pattern will occur. DSM diagnosis is expected to result in more negative ratings of a diagnosed person than is transitive diagnosis.

Hypothesis 2: Subjects who read a brief description of a man will perceive the man differently along a series of bipolar dimensions when the man is described as having a past psychological problem and given a DSM-III-R diagnosis than when the man is described as having a past psychological problem and given a transitive diagnosis.

In keeping with the first hypothesis, wherein it is predicted that subjects will desire greater social distance from a person when that person is described in DSM diagnosis terms than when described in transitive diagnosis terms, it is also predicted that subjects will see themselves as less similar to a person when the person is DSM diagnosed than when transitively diagnosed. This is expected because people will desire greater distance from a "sick" person with a "mental illness" than they will from a person whose thoughts and feelings are leading to maladaptive constructions of the world.

Hypothesis 3: Subjects who read a brief description of a man will rate the man as more dissimilar from themselves on a series of bipolar dimensions when the man is described as having a past psychological problem and given a DSM diagnosis than when the man is described as

> having a past psychological problem and given a transitive diagnosis. Further, it is predicted that subjects will rate the man as least dissimilar from themselves when the man is not described as having a psychological problem at all.

Further, because of the way in which the DSM diagnostic labels are expected to impact on subjects, subjects are predicted to perceive a diagnosed person as less similar to a typical person when the diagnosed person is described in DSM terms rather than transitive diagnosis terms.

> Hypothesis 4: Subjects who read a brief description of a man will rate the man as more dissimilar from a typical, normal person on a series of bipolar dimensions when the man is described as having a past psychological problem and given a DSM-III-R diagnosis than when the man is described as having a past psychological problem and given a transitive diagnosis. Further, it is predicted that subjects will rate the man as least dissimilar from a typical person when the man is not described as having a psychological problem at all.

The DSM disorders that will be presented in both DSM form and a translated transitive diagnosis form are adjustment disorder, dysthymia, and schizophrenia. The hypotheses above are expected to hold true for all three of these disorders.

CHAPTER 3
METHOD

Subjects

Subjects were 364 introductory psychology students. All were recruited through the University of Florida subject pool, and were tested in small groups of 5-12 subjects. Subjects signed up for the study by responding to a notice placed on the psychology department bulletin board. When the subjects arrived for the study, they were randomly assigned to one of three groups; this was accomplished by randomly distributing questionnaire booklets to subjects. Since subjects could receive one of three versions of the questionnaire booklet, their group was determined by the booklet they randomly received. Of the 364 subjects, 258 were white, 28 were African-American, 49 were Hispanic, and 29 were Asian. Mean age of subjects was 18.49 years.

Materials

A brief vignette of a man, adapted from Link et al. (1987), was used. The vignette described a man named Jim Johnson. While brief, it provided detailed information about his salary, personal hygiene habits, work behavior, job

aspirations, and plans to meet young women (Link et al., 1987). Seven versions of the vignette were used. In six of the seven versions, the vignette began with a paragraph describing Jim Johnson as having had a past psychological problem. Six versions described Jim with a past psychological problem because three different psychological problems were described, each in two different ways (once using DSM-III-R diagnosis terminology and once using transitive diagnosis terminology). In the first version of the vignette, Jim's psychological problem was described as an adjustment disorder. In the second version, his psychological problem involved the behaviors of an adjustment disorder, but was described in transitive diagnosis terms. In the third version of the vignette, Jim's psychological problem was described as dysthymia. In the fourth version, his psychological problem encompassed dysthymic behaviors, but was described in transitive diagnosis terms. In the fifth version of the vignette, Jim's psychological problem was described as histrionic personality disorder. In the sixth version, his psychological problem involved histrionic personality disorder behaviors, but was described in transitive diagnosis terms. In the seventh version, Jim was not identified as having a past psychological problem, and no diagnosis accompanied the vignette. The seven variations of the Jim Johnson vignette are reproduced in Appendix A.

Certain similarities existed between all three of the DSM-III-R diagnosis descriptions attached to the beginning of

the Jim Johnson vignette. First of all, each one presented Jim Johnson with a DSM-III-R diagnostic label, and then proceeded to describe what the disorder specified by that label involves. Descriptions of disorders were adapted from DSM-III-R descriptions; the only changes were to simplify the descriptions' language in order to make them more accessible to lay readers. Second, at the end of each DSM-III-R description was the following statement: "Once Jim Johnson received treatment he felt much better." This statement was included in order to maintain consistency with DSM-III-R's self described goal, in which a DSM-III-R diagnosis is the initial step "leading to the formulation of a treatment plan" (APA, 1987, p. xxvi). Further, this statement is consistent with the medically oriented language of DSM-III-R and the fact that virtually all DSM-III-R categories are contained in ICD-9.

Each of the three transitive diagnosis descriptions attached to the beginning of the Jim Johnson vignette presented the same information as its corresponding DSM-III-R diagnosis description. For example, the behaviors in the transitive diagnosis description of dysthymia corresponded to the dysthymic behaviors listed in both DSM-III-R and the DSM-III-R dysthymia description used in this study. That is, the same behaviors that are part of a DSM-III-R diagnosis of dysthymia were included in the transitive diagnosis translation of dysthymia. The same was true for the transitive diagnoses of adjustment disorder and

schizophrenia. All three transitive diagnoses included statements about the way Jim Johnson's problem "was caused by the way he construed events in his life." Further, all three noted that his behaviors constituted "responses to the way he thought and felt about events in his life." All ended with the following statement: "Once Jim learned to construe events differently he felt much better."

It was considered important to keep the information in all three transitive diagnoses consistent with information about the corresponding DSM-III-R disorders on which they were based. In this way, study results reflect differences in perceptions of the same information presented in two different ways. However, it is important to note that true transitive diagnoses are even more idiographic, detailed, descriptive, and process oriented than the ones employed in the current study (see Faidley & Leitner, 1993). However, in order to effectively compare transitive diagnosis to DSM-III-R diagnosis, transitive diagnoses needed to be created which would reflect specific DSM-III-R disorders and which could be easily and quickly presentable to subjects.

In order to assess reactions to the seven versions of the Jim Johnson vignette, a measure of social distance (Link et al., 1987) was used. This measure consists of seven items which assess the degree of social distance from Jim Johnson desired by respondents. Link et al. (1987) reported an internal consistency reliability rating of .92 for this measure (using Cronbach's α). Each item was scored using a

four-point Likert format (definitely unwilling, probably unwilling, probably willing, definitely unwilling), with "0" being "definitely unwilling" and "3" being "definitely willing." An overall social distance measure was obtained by adding together a subject's responses to each item, and then dividing the total by seven. All seven social distance items are included in their entirety in Appendix B.

Reactions to the seven versions of the vignette were also assessed using a series of 11 bipolar adjectives. These specific bipolar adjectives were first used by Chassin and her colleagues (Chassin, Eason, & Young, 1981; Chassin, Presson, Young, & Light, 1981) in a pair of studies of the effects of labeling on institutionalized adolescents, and later used by Burk and Sher (1990) in a study of labeling children of alcoholics. Because of the bipolar adjectives' usefulness in providing information about perceptions of deviance in these studies, they seemed particularly appropriate for use in the current study. The 11 bipolar adjectives were placed on seven point scales, modeled on those employed by Osgood, Suci, and Tannenbaum (1969), and were used to have subjects evaluate themselves, a "typical" person, and Jim Johnson. The adjectives employed, as well as the descriptors below each number on the seven-point scale, are contained in Appendix C.

Prior to the actual study reported herein, a 23 subject pilot study that used the procedures outlined above was conducted; at the conclusion of this pilot study, a "funnel

questionnaire" (see Page, 1969, 1971, 1973; Page & Kahle, 1976; Page & Scheidt, 1971) was given to subjects in order to insure that subjects were not influenced by the demand characteristics of the study (e.g. guessing the hypotheses, expecting particular responses are desired, etc.). With a funnel questionnaire, subjects begin by answering broad, open-ended questions about the study (e.g. "What was the purpose of this study?"), and proceed to more and more specific questions about the study until they are told the hypothesis and asked directly whether or not they figured it out while participating in the study. None of the pilot study subjects who completed the funnel questionnaire were able to guess any of the hypotheses of the experiment. The funnel questionnaire that was used in the pilot study can be found in Appendix D.

Procedure

Subjects were divided into seven groups of subjects. Each group was asked to read one version of the Jim Johnson vignette. The group that read the description of Jim Johnson containing no psychological problem or diagnosis served as a control group. The remaining six groups of subjects constituted experimental groups.

After reading one of the seven vignettes, subjects were asked to fill out the social distance items. In addition, they were asked to evaluate themselves, Jim Johnson, and a

"typical" person along each of the 11 bipolar adjective dimensions. In order to control for order of presentation effects, the order in which the social distance items and 11 bipolar adjectives were presented was counterbalanced; half of the subjects filled out the social distance items before completing bipolar adjective ratings, while the remaining subjects completed these tasks in reverse order. The order in which subjects rated themselves, Jim Johnson, and a "typical" person along the 11 bipolar adjective dimensions was also counterbalanced.

Once subjects read the vignette and completed the social distance scale and bipolar adjective ratings, they were thoroughly debriefed, and any questions they had were answered.

Two difference scores for each of the 11 bipolar adjective dimensions were calculated. The first score, herein called the "self difference" score, measures how differently subjects rated themselves from Jim Johnson; for each of the 11 bipolar dimension, this score was calculated by counting the number of points on the seven point scale between ratings of self and ratings of Jim Johnson. The second score, herein called the "typical difference" score, measures how differently subjects rated a "typical person" from Jim Johnson; for each bipolar dimension, this score was calculated by counting the number of points on the seven point scale between ratings of a "typical" person and ratings of Jim Johnson.

Subjects' difference scores were used to calculate two "overall dissimilarity" scores. The first of these, the "overall self dissimilarity" score, indicates subjects' rating of dissimilarity between themselves and Jim Johnson across all 11 bipolar dimensions. The "overall self dissimilarity" score was derived by summing each subject's 11 "self difference" scores. The second of these, the "overall typical dissimilarity" score, indicates subjects' rating of dissimilarity between a "typical person" and Jim Johnson across all 11 bipolar dimensions. The "overall typical dissimilarity" score was derived by summing each subject's 11 "typical difference" scores.

CHAPTER 4
RESULTS

The purpose of the study was to compare layperson reactions to Jim Johnson when he was described according to either transitive diagnosis or DSM-III-R diagnosis. It was hypothesized that when Jim Johnson was described according to DSM-III-R diagnosis, he would experience greater social rejection. In other words, it was predicted that when Jim Johnson was described in DSM-III-R terms, subjects would desire greater social distance from him, rate him as more dissimilar from themselves on a series of bipolar dimensions, and rate him as more dissimilar from a "typical" person on a series of bipolar dimensions than when he was described in transitive diagnosis terms. Table 1 provides descriptive statistics for all of the dependent measures for which there were significant differences based on type of diagnosis (DSM-III-R, transitive, or none).

Before the social rejection hypotheses were tested, a principal components factor analysis was performed in order to determine whether the three dependent measures (social distance, overall self dissimilarity, and overall typical dissimilarity) were independent of each other, and were each measuring a particular attribute of social rejection. The factor analysis suggested only two factors, determined using

the criterion of minimum eigenvalue greater than or equal to 1. A scree plot also indicated that a 2 factor solution was appropriate.

Table 1. Descriptive Statistics for Dependent Measures Yielding Significant Results For Type of Diagnosis

DEPENDENT MEASURE	COUNT	MEAN	S.D.
Social Distance			
DSM-III-R	155	1.142	.450
Transitive	157	1.159	.471
No Diagnosis	52	.648	.047
Negative Outward Impression			
DSM-III-R	155	3.462	.991
Transitive	157	3.425	.915
No Diagnosis	52	2.658	.105
Unacceptable Behavior			
DSM-III-R	155	5.475	1.049
Transitive	157	5.461	.963
No Diagnosis	52	5.987	.679

Overall self dissimilarity and overall typical dissimilarity both loaded highly on Factor 1; social distance constituted Factor 2 (see Table 2 for a summary of oblique factor loadings). Thus, in statistically analyzing the degree to which subjects socially rejected Jim Johnson, two measures were employed. The first measure collapsed overall self dissimilarity score and overall typical dissimilarity by averaging them together into an "overall dissimilarity" score. The second measure was social distance rating.

Table 2. Oblique Factor Loadings for Principal Components Factor Analysis of Social Rejection Measures

MEASURE	FACTOR 1	FACTOR 2
Overall Self Dissimilarity	.864	.061
Overall Typical Dissimilarity	.881	-.035
Social Distance Rating	-.003	.999

A one-way MANOVA was employed in order to test whether subjects rejected Jim Johnson based on the kind of diagnosis he was assigned. The independent variable of interest was type of diagnosis (DSM-III-R, transitive, or none). The dependent variables were the social distance rating and the overall dissimilarity score. MANOVAs testing the main and interaction effects of sex of subject and order of social distance scale presentation (i.e. whether or not subjects filled out the social distance scale rating for themselves or a "typical" person first) were also performed in order to test whether these variables influenced the results. No effect was found for sex of subjects, Wilk's lambda = 1.00, $F(2, 352) = .900$, $p > .05$, or for order of presentation, Wilk's lambda = 1.00, $F(2, 352) = .196$, $p > .05$. Further, there were no significant interaction effects for sex and type of diagnosis, Wilk's lambda = .98, $F(2, 352) = 13.394$, $p > .05$, or for sex and order, Wilk's lambda = 1.00, $F(2, 352) = .774$, $p > .05$. There also was no interaction effect for type of diagnosis and order, Wilk's lambda = .99, $F(2, 352) = .675$, $p > .05$. Finally, there was no three way interaction effect for type of diagnosis, order, and sex, Wilk's lambda = .99, $F(2, 352) = .941$, $p > .05$. Based on these statistics, it is safe to assume that sex and order of presentation variables did not confound the study's results.

The MANOVA testing the main effect of type of diagnosis was highly significant, Wilk's lambda = .86, $F(2, 352) = 13.876$, $p < .0001$. In other words, subjects responded

differently to Jim Johnson based on the type of vignette they read about him. In order to isolate the effect of type of diagnosis, two one-way ANOVAs were performed in order to determine whether type of diagnosis had a greater impact on social distance ratings or overall dissimilarity ratings. The ANOVA testing the effect of type of diagnosis on overall dissimilarity ratings did not produce significant results, $F(2, 361) = 1.90$, $p > .05$. However, the ANOVA testing the effect of type of diagnosis on social distance did produce a significant result, $F(2, 361) = 28.45$, $p < .0001$.

The Tukey-Kramer Honestly Significant Difference (HSD) procedure was used to further isolate the effect of diagnosis type on social distance scale ratings of Jim Johnson. Tukey-Kramer's procedure was chosen because it assumes that cell sizes are either equal or extremely different from each other. In the present study, cell sizes in the transitive and DSM-III-R diagnosis groups were extremely similar, but differed substantially from the no diagnosis group. Thus, Tukey-Kramer, which accounts for extremely different cell sizes, seemed appropriate. Results of the Tukey-Kramer procedure, which made all pairwise comparisons, indicated that subjects in the no diagnosis condition provided social distance ratings of Jim Johnson that were significantly different from those given by subjects in either the transitive diagnosis or DSM-III-R diagnosis conditions. That is, no diagnosis subjects desired significantly less social distance from Jim Johnson than transitive diagnosis subjects

or DSM-III-R diagnosis subjects. There was no significant difference in social distance ratings of Jim Johnson when comparing transitive diagnosis subjects to DSM-III-R subjects; both the transitive and DSM-III-R vignettes resulted in subjects desiring approximately equal amounts of social distance from Jim Johnson. Table 3 presents the results of the Tukey-Kramer comparisons in their entirety. See Figure 1 for a line graph of the way subjects in each of the three groups rated Jim Johnson on the social distance scale.

Table 3. Pairwise Comparisons of Type of Diagnosis for Social Distance Ratings Using Tukey-Kramer Procedure

COMPARISON	DIFFERENCE	CRITICAL DIFFERENCE
No diagnosis		
vs. DSM-III-R	.494	.168*
vs. Transitive	.511	.168*
DSM-III-R		
vs. Transitive	.017	.119

*indicates significant at the .05 level

Because three different DSM-III-R and transitive diagnosis vignettes were used, a secondary analysis was undertaken in order to ascertain whether or not results were confounded by the type of diagnosis vignette. This analysis involved a one-way MANOVA testing whether there was an interaction between type of diagnosis and type of vignette. This analysis was done separately because, had type of vignette been included in the original series of MANOVAs, it would have negated the effect of type of diagnosis by causing the same data to be included in both categories. The MANOVA

testing the interaction between type of diagnosis and type of vignette yielded no significant results, Wilk's lambda = .98, $F(2, 352) = 1.127$, $p > .05$. This MANOVA indicated that there was no interaction between the form of diagnostic vignette (histrionic, adjustment, or dysthymic) and the method of diagnosis (transitive or DSM-III-R).

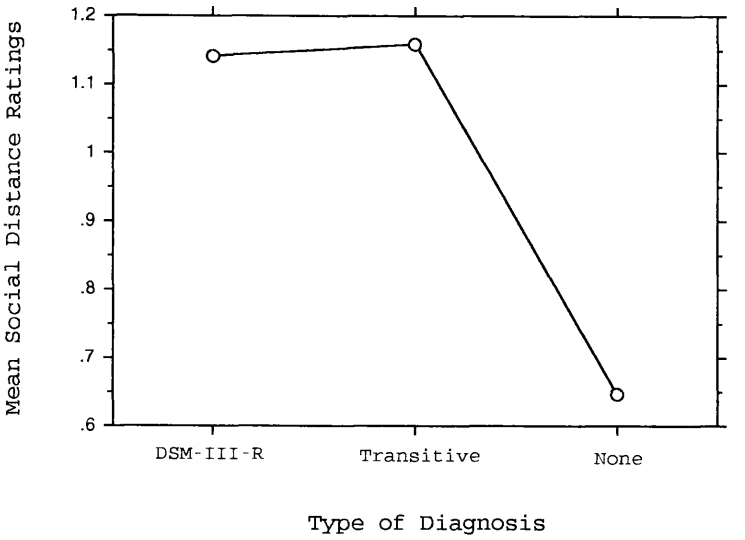

Figure 1. The Effects of Type of Diagnosis on Social Distance Ratings.

The study hypothesized that subjects would evaluate Jim Johnson differently along the bipolar dimensions depending upon which type of diagnosis (DSM-III-R, transitive, or none) he received. Prior to testing this hypothesis, a principal components factor analysis was performed. The factor analysis suggested inclusion of only three factors, determined using the criterion of minimum eigenvalue equal or

greater than 1. As in the previously reported factor analysis, a scree plot was also performed. The scree plot confirmed that a 3 factor solution was appropriate. Happy-sad, strong-weak, normal- abnormal, relaxed-nervous, and accepted-rejected all loaded highly on Factor 1. Obedient-rebellious, gentle-rough, and good-bad loaded highly on Factor 2. Active-inactive constituted Factor 3. Can control behavior-can't control behavior and friendly-unfriendly did not load highly on a single factor, and were therefore eliminated from subsequent analyses. Table 4 presents a summary of oblique factor loadings for the eleven bipolar dimensions.

Table 4. Oblique Factor Loadings for Principal Components Factor Analysis of Eleven Bipolar Dimensions

BIPOLAR DIMENSION	FACTOR 1	FACTOR 2	FACTOR 3
Happy-Sad	-.706	-.000	.142
Strong-Weak	.600	.097	-.246
Obedient-Rebellious	-.045	.813	-.018
Normal-Abnormal	-.672	.274	-.214
Relaxed-Nervous	.856	-.013	.233
Accepted-Rejected	.598	-.165	-.149
Gentle-Rough	.047	.828	.011
Good-Bad	-.090	.808	.202
Can control-behavior-Can't control behavior	.461	-.465	.043
Friendly-Unfriendly	.023	-.484	-.686
Active-Inactive	.104	-.087	.898

Subjects' ratings of Jim Johnson on the items that loaded on Factor 1 were averaged into a single Factor 1 score. Because all Factor 1 items seemed to revolve around the impact of one's outward appearance, this averaged score was named the "negative outward impression rating," with

lower scores constituting a more positive outward impression (appearing more happy, strong, normal, relaxed, and accepted) and higher scores constituting a more negative outward impression (appearing more sad, weak, abnormal, nervous, and rejected). Likewise, subjects' ratings of Jim Johnson on the items that loaded on Factor 2 were averaged into a single Factor 2 score. Because all Factor 2 items seemed to involve concerns about socially acceptable behavior, this score was named the "unacceptable behavior rating," with higher scores indicating greater expectations of socially acceptable behavior (obedience, gentleness, and goodness) and lower scores indicating greater expectations of socially unacceptable behavior (rebelliousness, roughness, and badness).

A one-way MANOVA was performed in order to test whether the negative outward impression rating, the unacceptable behavior rating, and the activity rating were influenced by type of diagnosis. This MANOVA yielded a highly significant result, Wilk's lambda = .905, $F(2, 352) = 5.989$, $p < .0001$. In order to assess whether or not this finding was confounded by sex and order of presentation effects, a series of MANOVAs testing the main and interaction effects of sex and order was performed. A MANOVA testing for sex effects, Wilk's lambda = .99, $F(2, 352) = 1.558$, $p > .05$, did not yield significant results. The sex and type of diagnosis interaction was also non-significant, Wilk's lambda = .99, $F(2, 352) = .823$, $p > .05$. There was no effect for order of presentation, Wilk's

lambda = .99, $F(2, 352) = 1.579$, $p > .05$, or for the order and type of diagnosis interaction, Wilk's lambda = .97, $F(2, 352) = 1.725$, $p > .05$. Further, no order and sex interaction was found, Wilk's lambda = 1.00, $F(2, 352) = .583$, $p > .05$. Finally, a MANOVA testing the three way interaction between type of diagnosis, order, and sex was not significant, Wilk's lambda = .99, $F(2, 352) = .348$, $p > .05$. These analyses indicate that sex and order of presentation did not confound the results.

One-way ANOVAs were done in order to further isolate the effect of type of diagnosis. The ANOVA testing the effect of type of diagnosis on negative outward impression rating was significant, $F(2, 361) = 13.143$, $p < .0001$, as was the ANOVA testing the effect of type of diagnosis on the unacceptable behavior rating, $F(2, 361) = 6.428$, $p < .01$. However, the ANOVA testing type of diagnosis and active-inactive rating was not significant, $F(2, 361) = .545$, $p > .05$.

Tukey-Kramer's Honestly Significant Difference was employed to test the effects of diagnosis on both outward impression rating and acceptable behavior rating. The Tukey tests on both negative outward impression rating and unacceptable behavior rating, which made all pairwise comparisons, indicated no significant differences between ratings of Jim Johnson in the DSM-III-R and transitive diagnosis conditions. However, significant results were found when comparing ratings of both negative outward impression and unacceptable behavior in both the DSM-III-R

and transitive conditions to ratings of these measures in the no diagnosis condition. That is, no diagnosis condition ratings of negative outward impression and unacceptable behavior were significantly different from both DSM-III-R and transitive condition ratings. See Tables 5 and 6 for the full results of the Tukey tests. Figures 2 and 3 present line graphs of subject's negative outward impression and unacceptable behavior ratings of Jim Johnson across the three diagnosis conditions.

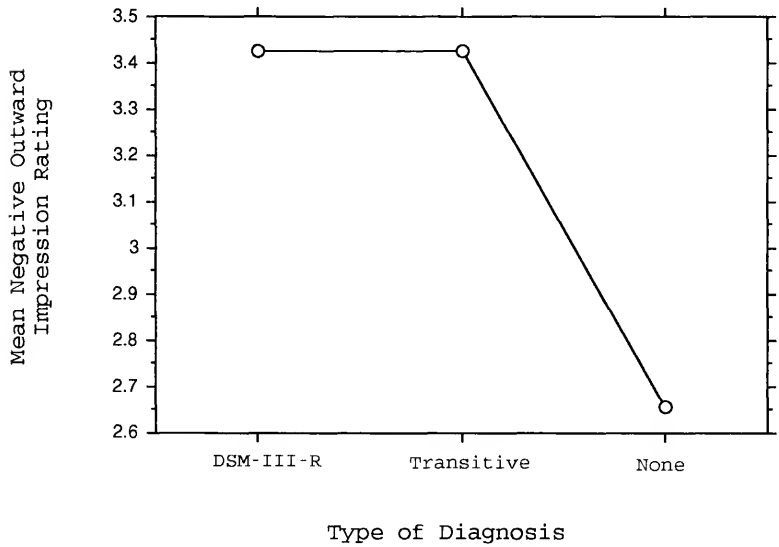

Figure 2. The Effects of Type of Diagnosis on Negative Outward Impression Ratings.

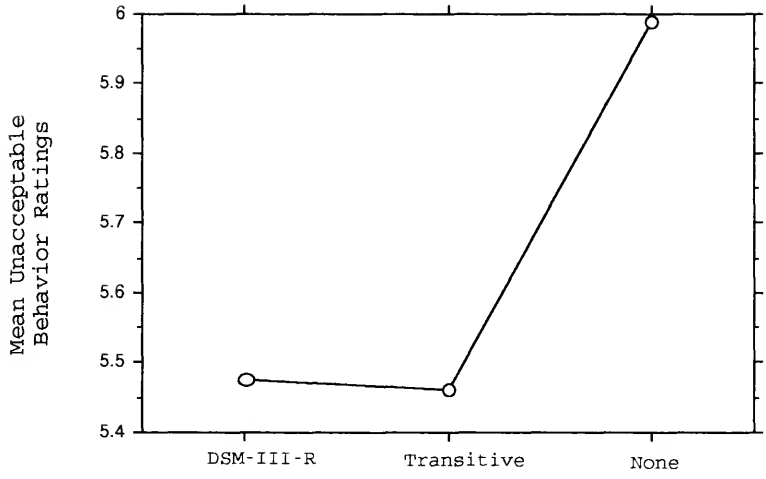

Figure 3. The Effects of Type of Diagnosis on Unacceptable Behavior Ratings.

Table 5. Pairwise Comparisons of Type of Diagnosis for Negative Outward Impression Ratings Using Tukey-Kramer Procedure

COMPARISON	DIFFERENCE	CRITICAL DIFFERENCE
No diagnosis		
vs. DSM-III-R	.768	.349*
vs. Transitive	.768	.350*
DSM-III-R		
vs. Transitive	-.000	.247

*indicates significant at the .05 level

Table 6. Pairwise Comparisons of Type of Diagnosis for Unacceptable Behavior Ratings Using Tukey-Kramer Procedure

COMPARISON	DIFFERENCE	CRITICAL DIFFERENCE
No diagnosis		
vs. DSM-III-R	.512	.365*
vs. Transitive	.526	.364*
DSM-III-R		
vs. Transitive	.015	.258

*indicates significant at the .05 level

Once it was found that subjects responded negatively to Jim Johnson in both DSM-III-R and transitive diagnosis conditions, a series of one-way ANOVAs was performed in order to examine whether or not subjects reacted more or less negatively to Jim Johnson as a function of the specific disorder he was assigned. These ANOVAs did not examine the effect of type of diagnosis (i.e. transitive or DSM-III-R); rather, they examined the effect of type of vignette (histrionic personality disorder, adjustment disorder, or dysthymia) across both DSM-III-R and transitive diagnosis conditions. This was done in order to expand upon the finding that subjects reacted negatively to Jim Johnson regardless of type of diagnosis. It seemed important to know whether the type of disorder a person was assigned affected the degree to which that person was negatively perceived.

Three ANOVAs were calculated, one for each dependent variable where significant differences were found in reactions to Jim Johnson when he was assigned any kind of psychological diagnosis. The ANOVA testing the effect of vignette type on social distance ratings produced significant results, $F(3, 360) = 28.50$, $p < .0001$; so did the ANOVA testing the effect of vignette type on negative outward impression rating, $F(3, 360) = 19.83$, $p < .0001$, and the ANOVA testing the effect of vignette type on unacceptable behavior rating, $F(3, 360) = 35.58$, $p < .0001$. Tukey-Kramer's Honestly Significant Difference was used to further isolate the results found in each of the three ANOVAs. For

two of the dependent measures (social distance rating and negative outward impression rating) subjects had a significantly more negative reaction to Jim Johnson regardless of the type of disorder he was assigned; in other words, subjects reacted more negatively to Jim when his diagnosis was more severe (histrionic personality disorder) and when it was less severe (dysthymia or and adjustment disorder) than they did when he was not diagnosed at all.

However, even though subjects desired significantly greater social distance from Jim Johnson and evaluated his outward impression as being more negative when Jim was given any of the three diagnoses, the Tukey Kramer analysis provided some clarification of this finding. It was found that subjects responded more negatively to Jim along all three dependent measures in the histrionic personality disorder condition than in the adjustment disorder or dysthymia conditions; this is expected, since the behaviors described in the histrionic personality disorder vignette appear more deviant than those described in either the dysthymia or adjustment disorder vignettes. Further, subjects did not rate Jim Johnson's behavior as significantly more unacceptable in the adjustment disorder or dysthymia conditions than they did in the no diagnosis condition. See Table 7 for vignette means for social distance, negative outward impression, and unacceptable behavior scores. Tables 8, 9, and 10 present the results of the Tukey-Kramer analyses.

Table 7. Descriptive Statistics for Dependent Measures Yielding Significant Results For Type of Diagnostic Vignette

DEPENDENT MEASURE	COUNT	MEAN	S.D.
Social Distance			
Adjustment Disorder	103	1.066	.403
Histrionic Disorder	105	1.322	.489
Dysthymia	104	1.062	.436
No Diagnosis	52	.648	.336
Negative Outward Impression			
Adjustment Disorder	103	3.249	.806
Histrionic Disorder	105	3.794	1.088
Dysthymia	104	3.229	.830
No Diagnosis	52	2.658	.756
Unacceptable Behavior			
Adjustment Disorder	103	5.783	.793
Histrionic Disorder	105	4.813	1.115
Dysthymia	104	5.817	.716
No Diagnosis	52	5.987	.679

Table 8. Pairwise Comparisons of Type of Diagnostic Vignette for Social Distance Ratings Using Tukey-Kramer Procedure

COMPARISON	DIFFERENCE	CRITICAL DIFFERENCE
No diagnosis		
vs. Dysthymia	.413	.189*
vs. Adj. Disorder	.418	.189*
vs. Histrionic	.673	.189*
Dysthymia		
vs. Adj. Disorder	.004	.155
vs. Histrionic	.260	.154*
Adjustment Disorder		
vs. Histrionic	.256	.154*

*indicates significant at the .05 level

Table 9. Pairwise Comparisons of Type of Diagnostic Vignette for Negative Outward Impression Ratings Using Tukey-Kramer Procedure

COMPARISON	DIFFERENCE	CRITICAL DIFFERENCE
No diagnosis		
vs. Dysthymia	.571	.393*
vs. Adj. Disorder	.591	.394*
vs. Histrionic	1.137	.393*
Dysthymia		
vs. Adj. Disorder	.020	.322
vs. Histrionic	.565	.320*
Adjustment Disorder		
vs. Histrionic	.546	.321*

*indicates significant at the .05 level

Table 10. Pairwise Comparisons of Type of Diagnostic Vignette for Unacceptable Behavior Ratings Using Tukey-Kramer Procedure

COMPARISON	DIFFERENCE	CRITICAL DIFFERENCE
Histrionic		
vs. Adj. Disorder	.970	.310*
vs. Dysthymia	1.005	.309*
vs. No Diagnosis	1.174	.379*
Adj. Disorder		
vs. Dysthymia	.034	.311
vs. No Diagnosis	.204	.380
Dysthymia		
vs. No Diagnosis	.170	.380

*indicates significant at the .05 level

CHAPTER 5
DISCUSSION

The results of the present study suggest that perceptions of an individual are negatively affected when that individual is described as having experienced a psychological problem. However, no evidence was found which indicates that transitive diagnoses result in less negative impressions of an individual than do DSM-III-R diagnoses. In other words, subjects desired significantly greater social distance from Jim Johnson, rated his outward impression more negatively, and rated his behavior as more socially unacceptable when he was assigned either a DSM-III-R or transitive diagnosis than when he was assigned no diagnosis at all. Such results imply that simply describing someone as having a psychological problem often leads to the creation of negative attitudes towards that person.

While the present study's results did not indicate that transitive diagnosis is less stigmatizing than DSM-III-R diagnosis, they did provide evidence that any kind of diagnosis has an impact on perceptions of the person being diagnosed. For the most part, the pattern of negative perceptions towards a person diagnosed with a psychological problem did not differ as a function of the disorder assigned. That is, subjects rated Jim Johnson's outward

impression as more negative, and their own desire to be socially distant from him as greater, regardless of both type of diagnosis (transitive or DSM-III-R) and the specific diagnosis he was assigned (histrionic personality disorder, dysthymia, or adjustment disorder). It made little difference whether Jim was described with an adjustment disorder, a histrionic personality disorder, or with dysthymia--subjects still reacted in a negative fashion towards him.

This should not imply that all diagnoses result in equally negative reactions to the person diagnosed. In fact, when Jim Johnson was assigned the histrionic disorder, reaction to him was significantly more negative with regard to social distance, outward impression, and acceptable behavior than it was when he was given an adjustment disorder, dysthymia, or no diagnosis at all. Thus, the more severe the disorder, the more negative the response to the person diagnosed. Nevertheless, even when a less severe diagnosis was made (an adjustment disorder is probably one of the least serious disorders in DSM-III-R), subjects rated Jim Johnson as someone they wanted to maintain significantly more social distance from and someone who makes a significantly worse outward impression than when he was not diagnosed. This result is somewhat surprising, given the general lack of severity usually associated with adjustment disorder diagnoses, and the mildness of the adjustment disorder description that was included as part of both the DSM-III-R

and transitive diagnosis vignettes for adjustment disorder. It implies that even though people respond most negatively to someone assigned a severe psychological diagnosis, they respond in only a somewhat less negative fashion to someone assigned a relatively benign psychological diagnosis. This seems to indicate that all psychological diagnoses can be stigmatizing. In spite of efforts on the part of the helping professions to destigmatize mental illness, this study's results can be interpreted as indicating that much stigma still accompanies being diagnosed with a mental disorder (or even simply being described as having once encountered a psychological problem).

Evaluating the Jim Johnson Vignette

As mentioned previously, the Jim Johnson vignette was developed by Link, et al. (1987) and used in a study that investigated the impact of labeling someone with a psychological problem. While using a vignette has the advantage of providing a seemingly more real scenario for subjects taking part in the study, it also can have its drawbacks. Below, some potential concerns about the vignettes used in the study are discussed.

Length of vignette. While there seems to be strong evidence supporting the notion that descriptions of a psychological problem result in negative impressions of the person whose problem is described, alternative explanations of the study's results can be offered. There are a number of

potential confounds which could explain the study's findings. For example, length of vignette might have affected subjects' ratings of Jim Johnson. All of the diagnosis vignettes (both DSM-III-R and transitive) were longer than the no diagnosis vignette; the histrionic DSM-III-R and transitive diagnosis vignettes were the longest of all. Perhaps the extra length influenced results. Subjects with the shorter vignette may have responded positively to Jim Johnson simply because the vignette and questionnaire were brief and easy to complete. While this may not seem a very likely explanation for the study's results, it cannot be entirely eliminated since the study did not control for length of vignette. Future experimenters doing similar studies might wish to take this into consideration.

Disproportionate negative information. The reason that the Jim Johnson vignette was used was so that more than one piece of information could be considered by subjects in evaluating him. However, it is still possible that subjects responded negatively to Jim in the DSM-III-R and transitive diagnosis conditions because the majority of information that they had about Jim involved his past psychological problem. In other words, had the information about Jim's psychological problem not taken up such a sizable percentage of the vignette, then perhaps subjects would not have rated him so negatively when he was assigned a psychological diagnosis. While the study's results indicate that a psychological diagnosis does impact on peoples' perceptions of a diagnosed

person, it remains unclear how much this impact can be negated by providing additional information about the diagnosed person. This brings to mind Rothaus, et al.'s (1963) study, which found that raters responded more positively to mental patients after interacting with them in person. Perhaps had the vignette been followed by a face to face interaction with a confederate posing as Jim Johnson, the study's results would have been different.

Operational definitions. Questions about subject selection also must be weighed against the relative novelty of the experiment; this experiment marks a first attempt to develop transitive diagnosis more fully and compare its effect on people's perceptions to that of DSM-III-R. Other personal construct psychotherapists may not consider the transitive diagnosis vignettes used in this study as constituting an appropriate representation of what a transitive diagnosis should be. Only as transitive diagnosis is further developed will consensus evolve regarding how to best operationally define it so that its impact (on both perceptions of diagnosed persons and on therapist's conceptualizations of clients) can be measured and compared to other forms of psychological diagnosis. Likewise, the study's DSM-III-R vignettes, even though modeled specifically on the DSM-III-R disorders they were designed to represent, may not have been ideal. Page and Yates (1975) found that placing different headings at the top of a survey about attitudes towards mental illness resulted in different

patterns of response on the part of subjects; generalizing from their research to the present study, alternative ways of presenting the DSM-III-R and transitive diagnosis information might result in different reactions on the part of subjects.

Critical Evaluation of Results

The study seems to indicate that psychological labels do impact negatively on people's perceptions of a diagnosed individual. However, this interpretation of the results should be tempered by considering a number of important research design issues. The most critical of these issues are briefly outlined and discussed below.

Demographic concerns. A primary concern involves the subjects employed in the experiment. The study used undergraduate psychology students with a mean age of approximately 18 as its subjects. Therefore, caution should be taken in generalizing the results of this study to persons of other age groups. Further, a very large majority of subjects (70%) were Caucasian. Again, this could have potentially influenced results. People from different ethnic and cultural backgrounds might react more or less negatively to the diagnostic vignettes because some cultures attach greater stigma to psychological problems than others. Had subjects from a larger cross section of age groups and ethnic backgrounds been tested, the study might have yielded somewhat different results.

Layperson knowledge. Subjects without much knowledge of psychiatric diagnosis were used in order to assure that subjects had approximately equal knowledge of transitive and DSM-III-R diagnosis; this was done in order to avoid confounding results by testing subjects who were very familiar with one form of diagnosis and unfamiliar with the other. However, it is possible that results were affected by subjects' inability to fully comprehend the diagnostic language that was part of each diagnosis; because they failed to understand such language, they may have responded more negatively to Jim Johnson when he was diagnosed with a psychological problem simply because the language used to describe Jim's problem sounded intimidating and incomprehensible. On the other hand, subjects may have had some working knowledge of diagnostic jargon, and inferred that when such jargon is used, it often implies that a person is seriously troubled; since this is frightening, subjects may have responded negatively to Jim Johnson in the diagnosis conditions.

Similarity of diagnostic vignettes. This brings us to the issue of why the prediction that subjects would react less negatively to Jim Johnson when he was described in transitive diagnosis terms rather than DSM-III-R diagnosis terms was not borne out by the results. Perhaps there is no difference in how subjects respond to different types of diagnosis--simply knowing that someone has had psychological difficulties (in and of itself a form labeling with powerful

implications for evaluating others) is enough to elicit negative reactions to a diagnosed person. This certainly makes sense, and seems to be a thoroughly viable explanation for the study's results.

However, an alternative possibility may be that the present study failed to provide subjects with vignettes that differed from one another enough to make a difference in peoples' perceptions of a diagnosed person. In other words, it is possible that the transitive diagnosis vignettes were simply too similar to the DSM-III-R vignettes to impact subjects' perceptions in a significantly less stigmatizing way. Transitive diagnosis is a difficult form of assessment to test empirically in comparison to DSM-III-R diagnosis because its basic format is so different from a DSM-III-R diagnosis and because, as mentioned earlier, it is still at an early stage of development and is somewhat hard to define operationally. In order to account for this, the experiment presented here offered subjects transitive diagnosis vignettes that only marginally altered the DSM-III-R disorder descriptions for which they were designed as alternatives. Perhaps a better way to have structured the study would have been to create transitive diagnosis vignettes that were more in keeping with those presented by Faidley and Leitner (1993), who elicit client constructs and then provide an in depth assessment of how such constructs are employed by the client. These vignettes could have been compared to DSM-III-R vignettes that provided more thorough elaboration of

corresponding DSM-III-R disorders. Had this approach been taken, the spirit of transitive diagnosis might have come through more clearly and resulted in differences in the way persons diagnosed in DSM-III-R or transitive terms were perceived. Then again, such a study also might have produced identical results to the current study.

The drawback of this alternative approach--and the primary reason it was not adopted for the study at hand--is that it involves a good many confounding variables. The less similar the vignettes become, the harder it is to identify what is causing differences in the way subjects react to transitive and DSM-III-R vignettes, if such differences are found at all. The results of the present study strongly suggest that emphasizing the constructive nature of a person's psychological problem in place of assigning a diagnostic label does little to help dispel negative perceptions of a psychological problem. In both cases, powerful, negative reactions occur. In other words, it appears that concerns over the impact of DSM-III-R diagnoses on perceptions of persons are warranted, or at least deserve further exploration. On the other hand, transitive diagnosis--as operationally defined and employed in the present study--does little to alter negative reactions to psychological diagnoses. Future researchers, in an attempt to develop less stigmatizing ways to discuss and diagnose psychological problems, might wish to investigate variations on transitive diagnosis that are somewhat different from the

form employed herein, or even explore other diagnostic approaches altogether different from both DSM-III-R and transitive diagnosis. Using transitive diagnosis may not result in less negative reactions to persons experiencing psychological problems. However, further research which investigates the impact of more "pure" forms of transitive diagnosis on perceptions of persons is encouraged.

Other studies. Given that this study is the first ever to investigate and compare people's reactions to transitive versus DSM-III-R diagnoses, most of its findings regarding reactions to transitive and DSM-III-R diagnosis need to be considered with caution. This seems especially important when recalling the many past studies on the impact of psychological labels, which have produced results that both confirm and disconfirm the effect that diagnostic labels have on perceptions of persons. The experiment described here is simply the latest study investigating this issue and must be considered within the context of other, similar studies. While a strong link was found in the present study between describing a person's psychological problem and negative attitudes towards that person, it still seems premature to conclude that such an effect occurs in all situations--especially when one considers the general lack of consensus in the area of diagnostic labeling (e.g., compare the conclusions of Gove, 1975; Link and Cullen, 1990; Rabkin, 1984; Scheff, 1966).

Conclusion

Debate is likely to continue over the impact of psychological diagnoses on perceptions of persons. Further, professionals will continue to argue about the relative merits and drawbacks of DSM-style diagnosis. The present study is the first known attempt to compare the impact of transitive diagnosis to DSM diagnosis. While the study's results can be interpreted in a number of ways, it does offer a beginning for those who wish to further explore the impact of transitive and DSM diagnoses on the way people are perceived. Results imply that diagnoses do influence perceptions of persons, and even suggest that the mere indication that someone has a psychological problem has negative repercussions for the way others react to such a person. While the degree to which labels and diagnoses are stigmatizing is controversial, it seems reasonable for mental health professionals to at least be aware of the possibility that diagnostic labels may affect clients and how others view them. Further, it seems important that those developing transitive diagnosis as an alternative to DSM-III-R attend to the way diagnosis impacts on clients because the present study found that transitive diagnosis produced negative reactions even though no explicit diagnostic label was involved. While the present study's results are certainly not conclusive, it provides both a beginning for further research on transitive and DSM-style diagnosis and another

piece of evidence in the ongoing debate over the effect of psychological diagnostic labels on persons experiencing psychological difficulties.

APPENDIX A
JIM JOHNSON DIAGNOSTIC VIGNETTES

DSM-III-R Adjustment Disorder Vignette

Here is a description of a 27 year old man. Let's call him Jim Johnson. About two years ago, Jim had a psychological problem. Jim's problem was caused by an Adjustment Disorder. The essential feature of Jim's disorder was a maladaptive reaction to a stressful time in his life. The reaction occurred three months after the onset of the stressful time, and persisted for about six months. The nature of Jim's reaction resulted in him experiencing difficulties at work, as well as in his social relationships with others. Jim's behaviors were responses to his disorder. Once Jim obtained psychotherapy to treat his disorder he felt much better.

Currently, Jim works at a job in a local business. He earns $20,000 a year before taxes and is doing well enough. He is well groomed and known for dressing neatly.

At his job, he gets along well with his co-workers and is on friendly terms with them. He begins his days chatting briefly with the people he works with and then gets down to business. He takes coffee and lunch breaks during the day, just like everyone else, and returns to work when his co-workers do.

While on the job, Jim checks his work carefully and doesn't pass it along until it is correct. This might slow Jim down a little, but he is never criticized for the quality of the work he completes.

Jim is interested in meeting and dating young women in the community. He is considering joining a local church group to meet them. He is also looking at a job that gives him more responsibility and pays better than his current one.

Transitive Adjustment Disorder Vignette

Here is a description of a 27 year old man. Let's call him Jim Johnson. About two years ago, Jim had a psychological problem. Jim's problem was caused by the way he construed (thought and felt about) events in his life. Due to the way he perceived events, Jim experienced a maladaptive reaction to a stressful time in his life. The reaction occurred three months after the onset of the stressful time, and persisted for about six months. The nature of Jim's reaction resulted in him experiencing difficulties at work, as well as in his social relationships with others. Jim's behaviors were responses to the way he thought and felt about events in his life. Once Jim obtained psychotherapy to help him think and feel differently about events (that is, construe them differently), he felt much better.

Currently, Jim works at a job in a local business. He earns $20,000 a year before taxes and is doing well enough. He is well groomed and known for dressing neatly.

At his job, he gets along well with his co-workers and is on friendly terms with them. He begins his days chatting briefly with the people he works with and then gets down to business. He takes coffee and lunch breaks during the day, just like everyone else, and returns to work when his co-workers do.

While on the job, Jim checks his work carefully and doesn't pass it along until it is correct. This might slow Jim down a little, but he is never criticized for the quality of the work he completes.

Jim is interested in meeting and dating young women in the community. He is considering joining a local church group to meet them. He is also looking at a job that gives him more responsibility and pays better than his current one.

DSM-III-R Dysthymia Vignette

Here is a description of a 27 year old man. Let's call him Jim Johnson. About two years ago, Jim had a psychological problem. Jim's problem was caused by the disorder of Dysthymia. The essential feature of Jim's disorder was a chronic disturbance of mood, involving depressed mood, for most of the day more days than not, for at least two years. During these periods of depressed mood he experienced disturbances in his diet and sleeping habits, and also experienced low energy and fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. Jim's behaviors were responses to his disorder. Once Jim obtained psychotherapy to treat his disorder he felt much better.

Currently, Jim works at a job in a local business. He earns $20,000 a year before taxes and is doing well enough. He is well groomed and known for dressing neatly.

At his job, he gets along well with his co-workers and is on friendly terms with them. He begins his days chatting briefly with the people he works with and then gets down to business. He takes coffee and lunch breaks during the day, just like everyone else, and returns to work when his co-workers do.

While on the job, Jim checks his work carefully and doesn't pass it along until it is correct. This might slow Jim down a little, but he is never criticized for the quality of the work he completes.

Jim is interested in meeting and dating young women in the community. He is considering joining a local church group to meet them. He is also looking at a job that gives him more responsibility and pays better than his current one.

Transitive Dysthymia Vignette

Here is a description of a 27 year old man. Let's call him Jim Johnson. About two years ago, Jim had a psychological problem. Jim's problem was caused by the way he construed (thought and felt about) events in his life. He perceived events in a way that led to a chronic disturbance of mood, involving depressed mood, for most of the day more days than not, for at least two years. During these periods of depressed mood he experienced disturbances in his diet and sleeping habits, and also experienced low energy and fatigue, low self-esteem, poor concentration, difficulty making decisions, and feelings of hopelessness. Jim's behaviors were responses to the way he thought and felt about events in his life. Once Jim obtained psychotherapy to help him think and feel differently about events (that is, construe them differently) he felt much better.

Currently, Jim works at a job in a local business. He earns $20,000 a year before taxes and is doing well enough. He is well groomed and known for dressing neatly.

At his job, he gets along well with his co-workers and is on friendly terms with them. He begins his days chatting briefly with the people he works with and then gets down to business. He takes coffee and lunch breaks during the day, just like everyone else, and returns to work when his co-workers do.

While on the job, Jim checks his work carefully and doesn't pass it along until it is correct. This might slow Jim down a little, but he is never criticized for the quality of the work he completes.

Jim is interested in meeting and dating young women in the community. He is considering joining a local church group to meet them. He is also looking at a job that gives him more responsibility and pays better than his current one.

DSM-III-R Histrionic Personality Disorder Vignette

Here is a description of a 27 year old man. Let's call him Jim Johnson. About two years ago, Jim had a psychological problem. Jim's problem was caused by Histrionic Personality Disorder. The essential feature of Jim's disorder was a pervasive pattern of emotionality and attention-seeking. He constantly sought or demand reassurance, approval, or praise from others and was uncomfortable in situations in which he was not the center of attention. His emotions were often expressed with exaggeration. He was very self-centered, with little or no tolerance for the frustration of delayed gratification. His actions were directed towards obtaining immediate satisfaction. He was attractive and seductive, often to the point of looking flamboyant and acting inappropriately. He was overly concerned with physical attractiveness. In addition, his speech was expressionistic and lacking in detail. For example, he might have described his vacation as "Just fantastic!" without being able to be more specific. Jim's behaviors were responses to his disorder. Once Jim obtained psychotherapy to treat his disorder he felt much better.

Currently, Jim works at a job in a local business. He earns $20,000 a year before taxes and is doing well enough. He is well groomed and known for dressing neatly.

At his job, he gets along well with his co-workers and is on friendly terms with them. He begins his days chatting briefly with the people he works with and then gets down to business. He takes coffee and lunch breaks during the day, just like everyone else, and returns to work when his co-workers do.

While on the job, Jim checks his work carefully and doesn't pass it along until it is correct. This might slow Jim down a little, but he is never criticized for the quality of the work he completes.

Jim is interested in meeting and dating young women in the community. He is considering joining a local church group to meet them. He is also looking at a job that gives him more responsibility and pays better than his current one.

Transitive Histrionic Personality Disorder Vignette

Here is a description of a 27 year old man. Let's call him Jim Johnson. About two years ago, Jim had a psychological problem. Jim's problem was caused by the way he construed (thought and felt about) events in his life. He perceived events in a way which led to emotionality and attention-seeking. He constantly sought or demanded reassurance, approval, or praise from others and was uncomfortable in situations in which he was not the center of attention. His emotions were often expressed with exaggeration. He was very self-centered, with little or no tolerance for the frustration of delayed gratification. His actions were directed towards obtaining immediate satisfaction. He was attractive and seductive, often to the point of looking flamboyant and acting inappropriately. He was overly concerned with physical attractiveness. In addition, his speech was expressionistic and lacking in detail. For example, he might have described his vacation as "Just fantastic!" without being able to be more specific. Jim's behaviors were responses to the way he thought and felt about events in his life. Once Jim obtained psychotherapy to help him think and feel differently about events (that is, construe them differently) he felt much better.

Currently, Jim works at a job in a local business. He earns $20,000 a year before taxes and is doing well enough. He is well groomed and known for dressing neatly.

At his job, he gets along well with his co-workers and is on friendly terms with them. He begins his days chatting briefly with the people he works with and then gets down to business. He takes coffee and lunch breaks during the day, just like everyone else, and returns to work when his co-workers do.

While on the job, Jim checks his work carefully and doesn't pass it along until it is correct. This might slow Jim down a little, but he is never criticized for the quality of the work he completes.

Jim is interested in meeting and dating young women in the community. He is considering joining a local church group to meet them. He is also looking at a job that gives him more responsibility and pays better than his current one.

No Diagnosis Vignette

Here is a description of a 27 year old man. Let's call him Jim Johnson.

Currently, Jim works at a job in a local business. He earns $20,000 a year before taxes and is doing well enough. He is well groomed and known for dressing neatly.

At his job, he gets along well with his co-workers and is on friendly terms with them. He begins his days chatting briefly with the people he works with and then gets down to business. He takes coffee and lunch breaks during the day, just like everyone else, and returns to work when his co-workers do.

While on the job, Jim checks his work carefully and doesn't pass it along until it is correct. This might slow Jim down a little, but he is never criticized for the quality of the work he completes.

Jim is interested in meeting and dating young women in the community. He is considering joining a local church group to meet them. He is also looking at a job that gives him more responsibility and pays better than his current one.

APPENDIX B
SOCIAL DISTANCE SCALE

Please answer the following questions about Jim Johnson. Please read each item carefully and fill in the blank next to each item by choosing a number from the scale below.

0 = definitely willing

1 = probably willing

2 = probably unwilling

3 = definitely unwilling

_____ 1. How would you feel about renting a room in your home to someone like Jim Johnson?

_____ 2. How about as a worker on the same job as someone like Jim Johnson?

_____ 3. How would you feel having someone like Jim Johnson as a neighbor?

_____ 4. How about as caretaker of your children for a couple of hours?

_____ 5. How about having your children marry someone like Jim Johnson?

_____ 6. How would you feel about introducing Jim Johnson to a young woman you are friendly with?

_____ 7. How would you feel about recommending someone like Jim Johnson for a job working for a friend of yours?

APPENDIX C
BIPOLAR ADJECTIVE DIMENSIONS

The following adjective dimensions were presented to subjects three times. Subjects rated Jim Johnson, themselves, and a typical person along these dimensions. Each dimension was placed along a seven point scale. Adjective decriptors besides each point of the scale were as follows:

"1" = extremely
"2" = quite
"3" = slightly
"4" = neutral
"5" = slightly
"6" = quite
"7" = extremely

The adjective dimensions were:

sad-happy
strong-weak
rebellious-obedient
abnormal-normal
relaxed-nervous
accepted-rejected
rough-gentle
bad-good
can control behavior-can't control behavior
friendly-unfriendly
inactive-active

Adjectives listed first were placed at the end of the scale labeled "1" and adjectives listed second were placed at the end of the scale labeled "7." All adjective dimensions were presented in the order in which they are listed above.

APPENDIX D
FUNNEL QUESTIONNAIRE

1. What did you think this experiment was all about?

2. What did you think the hypothesis was (i.e., what did you think we were looking for, trying to study, etc.)?

3. Was there anything about the description about Jim Johnson that seemed out of place to you? If so, explain what it was.

4. What was the purpose of filling out the ratings scales?

5. How did you go about deciding what ratings to give on the questionnaires?

6. Did you think that the experimenter might have expected that you would rate Jim Johnson in any certain way? In other words, was there a correct way to mark at least one of the scales? Explain.

7. In this experiment, the description of Jim Johnson was presented so that you would be forced to consider his psychological problem in evaluating him. While taking part in the study, did you notice or suspect this?

8. The experimenter expected that you would rate Jim Johnson more negatively than yourself or a typical, normal person. Did you ever expect this was the hypothesis?

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BIOGRAPHICAL SKETCH

Jonathan D. Raskin was born on July 23, 1968, in Brooklyn, New York. He attended Lynbrook High School, graduating in 1986. In 1990, he was awarded a Bachelor of Arts Degree in psychology from Vassar College, receiving both general and departmental honors. For the past five years, he has been a graduate student in counseling psychology at the University of Florida. Dr. Raskin obtained his Master of Science degree in 1992, and his Doctor of Philosophy degree in August, 1995. He completed his doctoral internship at Emory University's Counseling Center during the 1994-1995 academic year. Dr. Raskin has published a number of papers in the area of personal construct psychology and is currently interested in applying constructivist ideas to a variety of counseling issues, including psychological diagnosis, notions of sexuality, and ethics.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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